Supreme Court, U.S.
FILED

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No. _____

In the Supreme Court of the United States

OCTOBER TERM, 1995

LINCOLN NATIONAL LIFE INSURANCE COMPANY and EMPLOYERS HEALTH INSURANCE COMPANY,

PETITIONERS,

v.

ALLEN L. HARDESTER, JR. and BARBARA HARDESTER,

RESPONDENTS.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an accurate diagnosis of a sickness is a condition precedent to the application of a standard preexisting condition exclusion in an employee welfare benefit plan established pursuant to the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. § 1001 *et seq.*

RULE 29.1 STATEMENT

The parent company of petitioner, Lincoln National Life Insurance Company, is Lincoln National Corporation. The parent company of petitioner, Employers Health Insurance Company, is EMPHESYS Financial Group, Inc. Neither petitioner has any subsidiaries other than wholly-owned subsidiaries.

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In the Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-_____

Lincoln National Life Insurance Company
and Employers Health Insurance Company, Petitioners,

v.

Allen L. Hardester, Jr. and Barbara Hardester, Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITION FOR A WRIT OF CERTIORARI

Lincoln National Life Insurance Company and Employers Health Insurance Company (collectively, "Lincoln National") petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals on rehearing *en banc* (App., *infra*, 1a-6a) is reported at 52 F.3d 70. The opinion of the three-judge panel of the court of appeals (App., *infra*, 7a-27a) is reported at 33 F.3d 330. The opinion of the district court (App., *infra*, 28a-34a) is reported at 841 F. Supp. 714.

JURISDICTION

The panel of the court of appeals entered judgment on August 24, 1994. A timely petition for rehearing *en banc* was granted, thereby vacating the panel's judgment. App., *infra*, 36a-37a. Judgment of the *en banc* court of appeals was entered on April 18, 1995. App., *infra*, 2a. The court of appeals had jurisdiction pursuant to 28 U.S.C. § 1291. Jurisdiction in this Court is invoked pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides in relevant part:

> A civil action may be brought . . . by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan . . . .

STATEMENT OF THE CASE

Barbara Hardester's gynecologist discovered a mass in Mrs. Hardester's left breast during an annual physical examination. Although the physician believed the mass was benign, she was concerned about the possibility of breast cancer. As a precaution, Mrs. Hardester was referred to a surgeon. Several weeks later, Mrs. Hardester became eligible for benefits under a group health insurance plan issued by Lincoln National (the "Plan"), which contained a standard preexisting condition exclusion. A biopsy later revealed that the breast mass was cancerous. Mrs. Hardester filed a claim for benefits for the care and treatment she received for breast cancer. Lincoln National denied Mrs. Hardester's claim on the basis that Mrs. Hardester had

received "medical attention" from her gynecologist for a "sickness" within the Plan's definition of a preexisting condition.

A. Factual Background

In August 1981, Mrs. Hardester was diagnosed with fibrocystic disease. App., *infra*, 8a, 29a.[1] In April 1991, Mrs. Hardester's gynecologist, Dr. Phillips-Seitz, noted the presence of "shoddy nodularity to the breast tissue." App., *infra*, 8a-9a.[2] Dr. Phillips-Seitz did not, however, detect a "dominant" mass in either breast. App., *infra*, 8a.

During Mrs. Hardester's next gynecological examination on April 6, 1992, Dr. Phillips-Seitz discovered a dominant breast mass in Mrs. Hardester's left breast. App., *infra*, 9a, 21a. Although Dr. Phillips-Seitz believed this newly-discovered breast mass was a symptom of fibrocystic disease, the mass, in fact, was cancerous. App., *infra*, 9a-10a.

Based upon her discovery of the breast mass, Dr. Phillips-Seitz was more concerned about the possibility of breast cancer than she had been the previous year. App., *infra*, 9a-10a. As a precaution, Dr. Phillips-Seitz referred Mrs. Hardester to Dr. Boyle, a surgeon, for further examination of the mass. App., *infra*, 19a, 29a.

On May 1, 1992, Mrs. Hardester became eligible for benefits under the Plan. App., *infra*, 9a. The Plan contained a standard exclusion for preexisting conditions that received medical attention within the twenty-four months prior to

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[1] Fibrocystic disease is a benign condition of the breast that is manifest by fibrous tissue and cyst formation; it also may result in a firm area of the breast, called a mass. App., *infra*, 8a & n.1.

[2] "Shoddy nodularity" is a small, palpable mass. App., *infra*, 29a.

May 1, 1992. App., *infra*, 9a. The Plan defined a preexisting condition as:

> a Sickness or Bodily Injury for which You have received medical attention (care, treatment, services, medication, diagnosis or consultation) prior to . . . the effective date of Your medical policy.

App., *infra*, 9a. Further, the Plan defined a "sickness" as: (1) "a disturbance in function or structure of Your body"; (2) "which causes physical signs and/or symptoms and"; (3) "which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body." App., *infra*, 9a.

On the same day Mrs. Hardester became eligible for benefits under the Plan, Dr. Boyle examined Mrs. Hardester. App., *infra*, 10a, 22a. Like Dr. Phillips-Seitz, Dr. Boyle believed the mass "probably" was caused by fibrocystic disease. App., *infra*, 10a, 22a. A mammogram taken by Dr. Boyle was negative. App., *infra*, 10a.

On May 15, 1992, Dr. Boyle again examined Mrs. Hardester's left breast. App., *infra*, 10a. Because the condition of the mass had not changed since the prior examination, Dr. Boyle ordered a biopsy of the mass. App., *infra*, 10a, 22a. The biopsy conclusively established that the mass was cancerous. App., *infra*, 10a, 22a. Had the mass not been removed, Mrs. Hardester likely would have died from breast cancer. App., *infra*, 10a.

B. Procedural History

After exhausting Plan remedies, respondents filed a complaint in the United States District Court for the District of Maryland against Lincoln National, alleging Lincoln National's denial of benefits violated ERISA § 502(a)(1)(B),

29 U.S.C. § 1132(a)(1)(B). Jurisdiction in the district court was premised on 28 U.S.C. § 1331. After minimal discovery, Lincoln National filed a motion for summary judgment; respondents subsequently filed a cross-motion for summary judgment. On January 7, 1994, the district court granted respondents' motion and denied Lincoln National's motion. App., *infra*, 35a.

According to the district court, the Plan's preexisting condition exclusion did not apply because Dr. Phillips-Seitz had provided medical attention for fibrocystic disease, not for cancer. App., *infra*, 31a-32a. The district court further expressed the view that

> "[t]o dispense with the requirement of knowledge [of a sickness] is so perverse that even if a pre-existing condition clause expressly voided coverage for unknown conditions, it might be unenforceable as a matter of public policy. Certainly in light of the common law doctrine of *contra proferentum*,. . .a court would be reluctant to construe a pre-existing condition clause that is not explicit in not requiring knowledge or its equivalent."

App., *infra*, 33a - 34a (citations omitted).[3]

The district court found that at the time Dr. Phillips-Seitz discovered the mass, she believed there was "only" a one to five percent chance the mass was cancerous. App., *infra*,

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[3] Although the district court referred to the doctrine of *contra proferentum*, the Hardesters have never argued that any part of the Plan was ambiguous. Moreover, neither the district court nor the *en banc* court found that the Plan was ambiguous. *See* App., *infra*, 2a-3a, 5a, 28a-34a.

32a, n.3. Although the mass proved to be cancerous, the district court characterized the cancer as "coincidental" to the fibrocystic disease. App., *infra*, 32a.

On appeal, a divided panel of the Fourth Circuit reversed and remanded with instructions to enter judgment in favor of Lincoln National. App., *infra*, 20a. The panel held that the Plan's preexisting condition exclusion did not require an accurate diagnosis of cancer. App., *infra*, 15a, n.6. The panel also held that Mrs. Hardester's cancer was a sickness within the terms of the Plan because it: (1) disturbed the structure of her body; (2) exhibited a physical sign; and (3) if left unattended, would have caused a "deterioration" in the "state" of her health. App., *infra*, 14a-16a. The panel further held that, although Mrs. Hardester and Dr. Phillips-Seitz were unaware the mass was cancerous, Mrs. Hardester had received "care," "treatment," "services," or "consultation" for cancer three weeks before the Plan's effective date. App., *infra*, 16a.

The panel rejected the district court's reliance on "public policy" as a basis for requiring a diagnosis of a sickness as a condition precedent to the application of a preexisting condition exclusion. App., *infra*, 19a-20a. The panel held that ERISA plans must be interpreted according to the plan language, not public policy. App., *infra*, 20a.

The dissent from the panel opinion, adhering to the views expressed by the district court, described the mass in terms of two distinct conditions: a "large ropey fibrocystic mass" and a "small carcinoma," which was "coincident" to the fibrocystic disease. App., *infra*, 24a. Although it characterized the referral to the surgeon as "preventive care" (App., *infra*, 26a, n.5), the dissent nonetheless found that the gynecologist had provided medical attention only to the fibrocystic, not the cancerous, portion of the mass. App., *infra*, 24a-25a. The dissent echoed the district court's public

policy concerns about enforcing a preexisting condition exclusion before a sickness has been accurately diagnosed. App., *infra*, 27a.

On rehearing, the *en banc* court, in a 7-6 decision, affirmed the district court for the reasons stated in the dissent from the panel's opinion. App., *infra*, 2a-3a. The dissent from the *en banc* court adopted the reasoning stated in the panel opinion. App., *infra*, 3a-4a.

REASONS FOR GRANTING THE WRIT

The Fourth Circuit's decision conflicts with principles established in decisions of the Seventh and Eighth Circuits. As it now stands, the Fourth Circuit requires an accurate diagnosis of a sickness as a condition precedent to the application of a plan's preexisting condition exclusion; the Seventh and Eighth Circuits do not. As a result of this conflict, the application of an ERISA plan's preexisting condition exclusion depends not on the terms of the plan, but on the venue chosen for resolution of the claim.

The Fourth Circuit's decision, in conjunction with the conflicting decisions of the other courts of appeals, will result in inconsistent plan administration. Congress's intent as expressed in ERISA, as well as this Court's prior holdings, establishes that nationwide uniform administration of ERISA plans is an important policy underlying ERISA. This policy will be undermined by the conflicting directives of the courts of appeals.

The Fourth Circuit's decision has national importance because each year tens of thousands of individuals become covered under ERISA-governed health benefit plans, which exclude benefits for preexisting conditions. Indeed, the plan language at issue is included in group health insurance policies issued by Lincoln National to 19,000 employers, covering 271,000 lives, in forty-three states and the District

of Columbia. Moreover, the preexisting condition exclusion at issue is representative of exclusions found in ERISA plans issued by other group health insurers. Whether a sickness must be accurately diagnosed during the preexisting period is significant to plan participants, their employers and their group health insurers.

The Fourth Circuit's decision also has national importance because the resolution of the issue presented will impact on the cost of group health insurance. The cost of group health insurance is a substantial concern of ERISA plan participants and beneficiaries throughout the United States.

The Fourth Circuit's decision is contrary to the language in the Plan, the decisions of other courts of appeals, and the intent of Congress. Review by this Court is warranted.

I. THE FOURTH CIRCUIT'S DECISION CONFLICTS WITH THE DECISIONS OF OTHER COURTS OF APPEALS ON AN ISSUE OF NATIONAL IMPORTANCE

The Fourth Circuit held that a standard preexisting condition exclusion in an ERISA plan is effective only if a sickness is accurately diagnosed before the Plan's effective date. App., *infra*, 23a-26a. The Seventh and Eighth Circuits have held that a standard preexisting condition exclusion in an ERISA plan does not require an accurate diagnosis of a sickness before the plan's effective date. App., *infra*, 18a-19a.

The Fourth Circuit's decision conflicts with the Seventh Circuit's decision in *Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429 (7th Cir. 1994). In *Bullwinkel*, Mrs. Bullwinkel detected a lump in her left breast. *Id.* at 430. Eleven days before the ERISA plan's effective date, Mrs. Bullwinkel's physician diagnosed the lump as a cyst and assured Mrs. Bullwinkel that the cyst probably was benign.

The physician, however, was concerned about the possibility of cancer. To "'be safe,'" the physician referred Mrs. Bullwinkel to a surgeon for a biopsy. *Id.*

Several weeks after Mrs. Bullwinkel became covered under the ERISA plan, a biopsy revealed that the lump was cancerous. *Id.* Mrs. Bullwinkel sought benefits for her surgery and cancer treatment. Benefits were denied based on the plan's preexisting condition exclusion. *Id.*[4]

The Seventh Circuit affirmed the district court's grant of summary judgment in favor of the insurer. The Seventh Circuit held that, although Mrs. Bullwinkel was "never 'seen, treated, [or] diagnosed' specifically for breast cancer" prior to the effective date of the plan, she "was 'seen, treated, [and] diagnosed' . . . for a breast lump. . ." *Id.* at 432. Because the lump was cancerous, the Seventh Circuit concluded that Mrs. Bullwinkel had actually been "seen" or "treated" for cancer within the six months prior to the plan's effective date. *Id.* at 432. Any post-policy treatment for cancer, therefore, was excluded. *Id.* The Seventh Circuit rejected the argument that the cancer was not a preexisting condition because it had not been accurately diagnosed until after the plan's effective date. *Id.* at 431-32.

In the present case, the *en banc* court initially states that "I am not sure that I agree with *Bullwinkel* . . . " App.,

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[4] The New England Mutual pre-existing condition exclusion provided in pertinent part: "No benefits are payable for a condition, sickness, or injury for which you or your dependent were seen, treated, diagnosed, or incurred medical expense in the six-month period just before insurance starts . . . ." 18 F.3d at 430. This provision is identical in relevant part to the limitation in the Plan. App., *infra*, 9a.

infra, 27a.[5] The court further states that *Bullwinkel* "is easily distinguishable from this case" because "the cancerous lump was discovered before the effective date in *Bullwinkel*; here, the cancerous lump was discovered after the effective date." App., *infra*, 27a.[6] The Court's attempt to distinguish *Hardester* from *Bullwinkel* must fail.

Here, as in *Bullwinkel*, one mass was discovered and evaluated by the physician during the exclusionary period. Here, as in *Bullwinkel*, the physician initially believed that the mass was benign, but nevertheless was concerned that the mass might be cancerous. Here, as in *Bullwinkel*, the physician made a referral to a surgeon as a precaution against cancer. Here, as in *Bullwinkel*, the biopsy revealed that the mass was "cancerous." In sum, the facts and plan language in *Bullwinkel* are indistinguishable from the facts and plan language in this case. The decisions of the Fourth and Seventh Circuits are irreconcilably in conflict.

The Fourth Circuit's decision also conflicts with the principles established in the Eighth Circuit's decision in *Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504 (8th Cir. 1991). In *Kirk*, plaintiff was seen by his physician, two months prior to the ERISA plan's effective date, for symptoms that led the physician to suspect a congenital heart

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[5] The dissent from the *en banc* court concluded that *Bullwinkel* "considered the specific issue presented by the instant case." App., *infra*, 17a. The dissent also expressed agreement with the Seventh Circuit's decision in *Bullwinkel*. App., *infra*, 18a-19a.

[6] The court also cites in support of its decision the entirely dissimilar case of *Hughes v. Boston Mut. Life Ins. Co.*, 26 F.3d 264 (1st Cir. 1994). App., *infra*, 3a, n.2. For the reasons stated in the dissenting opinion (App., *infra*, 4a-6a), *Hughes* has no bearing on the outcome of this case.

disease. A blood test that should have detected the disease, however, proved negative. *Id.* at 505-06. Plaintiff subsequently became a participant in an ERISA health benefit plan that excluded preexisting conditions. *Id.* at 505.[7] Two months after the plan took effect, plaintiff was diagnosed with bacterial endocarditis, an infection of the heart valve. *Id.* at 506. The Court was unpersuaded by the fact that the illness was not diagnosed until after the policy became effective. *Id.* Accordingly, the Eighth Circuit held that plaintiff's sickness was a preexisting condition excluded by the terms of the ERISA plan. *Id.*

In the present case, the *en banc* court summarily rejected the Eighth Circuit's holding in *Kirk*, stating "simply that I agree with [the] dissent in that case." App., *infra*, 27a, n.6. The dissent from the *en banc* court, however, cites to and relies upon *Kirk*, explaining that "[t]he Eighth Circuit also adheres to the view expressed [by the Seventh Circuit] in *Bullwinkel.*" App., *infra*, 18a & n.9. The Fourth Circuit's decision in this case cannot be harmonized with the Eighth Circuit's decision in *Kirk*.

A number of district courts also have addressed the question of whether preexisting condition exclusions in ERISA plans apply to sicknesses not accurately diagnosed until after the plan's effective date. Indeed, the district courts, applying preexisting condition exclusions that are substantially similar to the Plan, likewise are divided on this issue. *Compare McCorkle v. Life Gen. Sec. Ins. Co.*, 830 F. Supp. 1446, 1449 (M.D. Fla. 1993) (preexisting condition exclusion bars recovery even though the sickness was not

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[7] The preexisting condition exclusion provided that "'no benefits [were] payable for expenses due to any Injury or Illness beginning before the effective date of the coverage.'" 942 F.2d at 505.

diagnosed until after the effective date), *Fischman v. Blue Cross & Blue Shield of Conn., Inc.*, 775 F. Supp. 513, 516 (D. Conn. 1991) (same) *and Cury v. Colonial Life Ins. Co. of Am.*, 737 F. Supp. 847, 854-55 (E.D. Pa. 1990) (same) *with Pitcher v. Principal Mut. Life Ins. Co.*, 870 F. Supp. 903, 907-08 (S.D. Ind. 1994) (preexisting condition exclusion does not bar recovery of plan benefits because physician did not diagnose breast cancer until after the plan's effective date).

Based on the conflicting decisions, an insurer administering a nationwide plan may grant or deny benefits based solely on the location of the claimant, not on the plan terms. Thus, two claimants covered by the same plan, based on the same facts, may well receive the exact opposite benefits determination. This result is anathema to this Court's holding that ERISA was intended

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 115 S. Ct. 1671, 1677 (1995) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)); *see also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987). The conflict among the courts, the importance of this issue to plan participants and beneficiaries,

and the problems the decisions create for plan administration, warrant issuance of a writ of certiorari.

II. THE FOURTH CIRCUIT'S DECISION IS BASED ON PUBLIC POLICY

The *en banc* court opined that "preventive care" for cancer is not "care" for cancer. App., *infra*, 26a, n.5.[8] The court's attempt to distinguish "preventive care" from "care" finds no support in the Plan. The Plan's definition of "medical attention" specifically includes "care," preventive or otherwise. App., *infra*, 9a. Based on the plain meaning of the Plan terms, the "preventive care" for cancer provided to Mrs. Hardester was "care" for cancer. The court, therefore, should have directed the entry of judgment in favor of Lincoln National.

The only logical explanation for the *en banc* court's conclusion that "preventive care" is not "care" for cancer is that public policy prohibits this result. The *en banc* court effectively modified the Plan, *sub silentio*, to impose its views on preventive care.

The Fourth Circuit's reliance on public policy conflicts with the Seventh Circuit's consideration and rejection of a similar argument to modify an ERISA plan's preexisting condition exclusion on "public policy" grounds. *Bullwinkel*, 18 F.3d at 431. The Seventh Circuit explained that "we must

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[8] The majority also questioned whether public policy "would permit the enforcement of a preexisting condition clause, like the one here, that wholly dispenses with a requirement that the patient know (or have reason to know) of his condition on the effective date." App., *infra*, 27a. Such a clause would, according to the majority, "'set a trap for the unwary purchaser of health insurance policies.'" App., *infra*, 27a (quoting *Mutual Hosp. Ins., Inc. v. Klapper*, 288 N.E.2d 279, 282 (Ind. App. 1972)).

give effect to the words which denote the bargain, not in light of public policy considerations, but in light of their plain meaning." *Id.*

Adherence to written plan terms also is important in light of Congress's emphasis on the need for written plans. *See* 29 U.S.C. §§ 1021-1031. Courts of appeals likewise have acknowledged the importance of adherence to the plain terms of an ERISA plan. *See, e.g., Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1452 & n.1 (5th Cir. 1995) (plain language in ERISA plans should be given its ordinary meaning); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 105-06 (8th Cir. 1992) (per curiam) (same); *Senkier v. Hartford Life & Acc. Ins. Co.*, 948 F.2d 1050, 1052-53 (7th Cir. 1991) (same); *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1439 (9th Cir. 1990) (same); *Burnham v. Guardian Life Ins. Co. of Am.*, 873 F.2d 486, 489 (1st Cir. 1989) (same); *see also Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 56 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 1051 (1993) ("While a court should be hesitant to depart from the written terms of a contract under any circumstances, it is particularly inappropriate to do so in cases involving ERISA, which places great emphasis upon adherence to the written provisions in an employee benefit plan.") The Court should issue a writ of certiorari to determine whether the terms of a preexisting condition exclusion in an ERISA plan may be modified based on "public policy" to require an accurate diagnosis of a sickness.

III. THE FOURTH CIRCUIT'S DECISION LIKELY WILL INCREASE THE COST OF BENEFITS PROVIDED THROUGH FULLY- INSURED ERISA PLANS

The Plan's preexisting condition exclusion limits coverage for any "sickness" that receives "medical attention" within twenty-four months prior to the Plan's effective date. App., *infra*, 9a. The exclusion is "an objective manifestation

of mutual intent to insure against the risk of future illness or injury, not against the risk that an earlier diagnosis turns out to be wrong." *Golden Rule Ins. Co. v. Atallah*, 45 F.3d 512, 519 (1st Cir. 1995). The effect of the exclusion is to place the risk associated with a sickness that receives medical attention before the Plan's effective date on the insured.

By not enforcing the Plan terms, the Fourth Circuit shifted the risk associated with an erroneous pre-coverage diagnosis of a sickness from a plan participant or beneficiary to an insurer. If the Fourth Circuit's decision is permitted to stand, Lincoln National, as well as other group health insurers, likely will charge additional premiums for this additional risk. The cost of group health insurance is a matter of significant concern to employers, employees, plan participants and beneficiaries.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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July 14, 1995

APPENDIX A

PUBLISHED
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 94-1172

ALLEN L. HARDESTER, JR.;
BARBARA HARDESTER,

Plaintiffs-Appellees,

v.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY, administrator,
EMPLOYERS HEALTH INSURANCE COMPANY,

Defendants-Appellants.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
J. Frederick Motz, Chief District Judge.
(CA-93-1685-JFM)
Argued: March 7, 1995
Decided: April 18, 1995
Before Chief Judge **ERVIN, RUSSELL, WIDENER, HALL, MURNAGHAN, WILKINSON, WILKINS, NIEMEYER, HAMILTON, LUTTIG, WILLIAMS**, and **MICHAEL**, Circuit Judges, and **PHILLIPS**, Senior Circuit Judge.

Affirmed by published per curiam opinion. Judge Hamilton wrote a dissenting opinion, in which Chief Judge Ervin, Judge Russell, Judge Wilkinson, Judge Luttig, and Senior Judge Phillips joined.

COUNSEL

ARGUED: Bryan David Bolton, SHAPIRO & OLANDER, Baltimore, Maryland, for Appellants. David Alan Titman, Ellicott City, Maryland, for Appellees. **ON BRIEF**: Michael E. McCabe, Jr., SHAPIRO & OLANDER, Baltimore, Maryland, for Appellants.

OPINION

PER CURIAM:

Lincoln National Life Insurance Company and Employers Health Insurance Company appeal an order of the district Court granting summary judgment for the plaintiff insureds in a dispute over health insurance coverage provided under an ERISA[1] welfare benefit plan. *Hardester v. Lincoln National Life Insurance Co.*, 841 F. Supp. 714 (D. Md. 1994). A divided panel of this court reversed the judgment of the district court, *Hardester v. Lincoln National Life Insurance Co.*, 33 F.3d 330 (4th Cir. 1994), but, on plaintiffs' suggestion, we vacated the panel decision and reheard the case en banc. Having considered the briefs and the arguments of the parties, we now affirm the judgment of the district court for the

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[1] Employee Retirement Income Security Act, 29 U.S.C. §§ 1001 *et seq.*

reasons stated in the dissent to the panel opinion. *Id.* at 337-340 (Hall, J., dissenting).[2]

AFFIRMED

HAMILTON, Circuit Judge, dissenting:

Appellants Lincoln National Life Insurance Company and Employers Health Insurance Company (the Appellants) appeal from the district court's grant of summary judgment in favor of Barbara and Allan J. Hardester, Jr. (the Hardesters) on their action to collect insurance benefits under a health insurance plan (the Plan) issued by the Appellants. *See Hardester v. Lincoln National Life Ins. Co.*, 841 F. Supp. 714 (D. Md. 1994). A divided panel of this court reversed and remanded the case to the district court with instructions to enter judgment for the Appellants. *See Hardester v. Lincoln National Life Ins. Co. (Hardester I)*, 33 F.3d 330 (4th Cir. 1994). Subsequently, a majority of this court elected to hear the case *en banc*, thereby vacating the panel opinion. *See* Fed. R. App. P. 35. The *en banc* court affirmed the grant of summary judgment in favor of the Hardesters.

Following rehearing *en banc*, I remain firmly convinced that the district court's grant of summary judgment in favor of

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[2] Though their authority is not essential to our decision, we note that two cases decided after the panel heard argument in this case support today's result. *Hughes v. Boston Mutual Life Insurance Co.*, 26 F.3d 264, 268-269 (1st Cir. 1994) (rule of *contra proferentum* precludes rejecting, on summary judgment, plaintiff's contention that treatment is "for" a condition only if there is "some awareness on the part of the physician or the insured that the insured is receiving treatment for the condition itself"); *Pitcher v. Principal Mutual Life Insurance Co.*, 870 F. Supp. 903, 910 (S.D. Ind. 1994) (expressly adopting analysis of *Hardester* panel dissent in strikingly similar case).

the Hardesters should be reversed and judgment should be entered in favor of the Appellants. Accordingly, I respectfully dissent for the reasons stated in the majority panel opinion in *Hardester I*. *See Hardester I*, 33 F.3d at 331-37. Concluding that *Hardester I* was properly decided, I would adopt it as the opinion of the *en banc* court.

The majority opinion only addresses two cases not addressed in *Hardester I*: *Hughes v. Boston Mutual Life Insurance Co.*, 26 F.3d 264 (1st Cir. 1994), and *Pitcher v. Principal Mutual Life Insurance Co.*, 870 F. Supp. 903 (S.D. Ind. 1994). *Hughes* involved the application of a "pre-existing condition" exclusion clause in a group health insurance plan. A University of Massachusetts employee who was insured under the plan brought an action against his insurer seeking benefits for the treatment of his multiple sclerosis (MS), after the insurer denied benefits based on the "pre-existing condition" exclusion clause. *Hughes*, 26 F.2d at 266-67.

The "pre-existing condition" clause in *Hughes* excluded coverage for a disability which was caused by or resulted from a pre-existing condition and which began in the first twelve months after the insured's effective date of coverage under the plan—the probationary period—unless the insured had received no treatment for the condition for six consecutive months after his effective date of coverage. *Id.* at 266. Under the plan, "treatment" was defined as "'consultation, care or services provided by a physician including diagnostic measures and taking prescribed drugs and medicines.'" *Id.* at 266 (quoting plan). "Pre-existing condition" was defined as "'sickness or injury for which the insured received treatment within six months prior to the insured's effective date ['the pre-probationary period'].'" *Id.* (alteration in original) (quoting plan). Notably, unlike the Plan in the case before us, the plan in *Hughes* did not define the term "sickness." Hughes experienced a number of symptoms consistent with MS for

which he received treatment during the pre-probationary period. At this time, the doctor prescribed medication for Hughes' symptoms but made no diagnosis of MS. After the pre-probationary period, Hughes was diagnosed with MS. Finding that Hughes had received treatment for his undiagnosed MS during the pre-probationary period, the district court granted the insurer's motion for summary judgment, and Hughes appealed. *Hughes*, 26 F.3d at 267.

Completely different from the case before us, the *Hughes* court found that the language of the "pre-existing condition" exclusion clause, including the term "sickness," was susceptible of more than one reasonable interpretation, and thus was ambiguous. *Id.* at 269-70. The *Hughes* court recognized that one reasonable interpretation would be that the clause does not require diagnosis to apply and another would be the opposite. *Id.* at 269. Applying the general contract rule that ambiguities are construed against the drafter, the *Hughes* court adopted, for purposes of summary judgment, the interpretation advanced by Hughes that the "pre-existing condition" clause, in order to exclude coverage, required diagnosis of the sickness during the pre-probationary period. *Id.* at 270. Because the evidence was undisputed that neither Hughes nor the physicians who treated his symptoms during the pre-probationary period was aware that he was being treated for MS, *i.e.*, Hughes' MS was undiagnosed, the *Hughes* court vacated the grant of summary judgment in favor of the insurer and remanded for further proceedings. *Id.*

Hughes is distinguishable from the case before us on two significant grounds, and thus does not support the majority's decision. First, the Hardesters have never argued that the pre-existing condition exclusion clause in the Plan was ambiguous. *See Hardester I*, 33 F.3d at 330-33. Second, the Plan defines the term "sickness," thus avoiding any ambiguity as to whether diagnosis is required for the clause to apply.

Accordingly, contrary to the majority's position, *Hughes* does not support its decision.

The second case that the *en banc* majority addresses in its opinion is *Pitcher v. Principal Mutual Life Insurance Co.*, 870 F. Supp. 903 (S.D. Ind. 1994). I need not distinguish *Pitcher* because it expressly adopted the analysis of the dissent in *Hardester I*, which is sufficiently addressed in the majority opinion in *Hardester I* and on which I now rely as the reasoning for my dissent.

In sum, as is fully developed in *Hardester I*, the majority disregards the plain language of the Plan that reveals the pre-existing condition exclusion works to deny coverage in this case. While I am certainly sympathetic to Barbara Hardester's sickness, as a jurist, I am unquestionably charged with applying the law, and I must not allow sympathy to cloud my legal judgment.

Chief Judge Ervin, Judge Russell, Judge Wilkinson, Judge Luttig and Senior Judge Phillips have joined this dissent.

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APPENDIX B

PUBLISHED
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

ALLEN L. HARDESTER, JR.;
BARBARA HARDESTER,

Plaintiffs-Appellees,

v.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY, administrator;
EMPLOYERS HEALTH INSURANCE COMPANY,

No. 94-1172

Defendants-Appellants.

Appeal from the United States District Court
for the District of Maryland, at Baltimore.
J. Frederick Motz, District Judge.
(CA-93-1685-JFM)

Argued: June 8, 1994
Decided: August 24, 1994

Before **HALL** and **HAMILTON**, Circuit Judges, and
PHILLIPS, Senior Circuit Judge.

ABLE COPY

Reversed and remanded with instructions by published opinion. Judge Hamilton wrote the majority opinion, in which Senior Judge Phillips joined. Judge Hall wrote a dissenting opinion.

COUNSEL

ARGUED: Bryan David Bolton, SHAPIRO & OLANDER, Baltimore, Maryland, for Appellants. David Alan Titman, Ellicott City, Maryland, for Appellees. **ON BRIEF**: Michael E. McCabe, Jr., SHAPIRO & OLANDER, Baltimore, Maryland, for Appellants.

OPINION

HAMILTON, Circuit Judge:

Defendants-appellants, Lincoln National Life Insurance Company (Lincoln National) and Employers Health Insurance Company (Employers Health) (collectively referred to as "the Defendants"), appeal the January 7, 1994 order of the district court granting the cross-motion for summary judgment of the plaintiffs-appellees, Barbara and Allen J. Hardester, Jr., on their action to collect insurance benefits and denying the Defendants' motion for summary judgment. For the reasons stated herein, we reverse and remand with instructions to enter judgment in favor of the Defendants.

I

In August 1981, Barbara Hardester (Barbara) was diagnosed with fibrocystic disease.[1] Until April 1991, annual gynecological checkups did not reveal the presence of any breast mass. On April 17, 1991, however, Dr. Barbara

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[1] This disease is a benign condition of the breast marked by fibrous tissue and cyst formation. In some cases, fibrocystic disease may result in the formation of a firm area in the breast called a mass.

Phillips-Seitz (Dr. Phillips-Seitz) found "shoddy nodularity to the breast tissue," or small, palpable masses, in the "upper outer quadrants" of Barbara's breasts. (J.A. 67-68). Dr. Phillips-Seitz referred Barbara Hardester to a surgeon, Dr. Mary F. Boyle (Dr. Boyle), who, in May 1991, confirmed that, although Barbara had small masses in her breasts, they were consistent with fibrocystic breast disease.

On May 1, 1992, Barbara became eligible for benefits under a group health insurance plan (the Plan) issued by the Defendants to the employer of her husband, Allen L. Hardester, Jr. (Allen)[2]. The Plan excluded coverage for pre-existing conditions for which medical attention was received during the twenty-four months prior to May 1, 1992. Under the Plan, a pre-existing condition was defined as:

> a Sickness or Bodily Injury for which You have received medical attention (care, treatment, services, medication, diagnosis or consultation) prior to:
>
> 1. The effective date of Your medical . . . coverage under this Policy[.]

(J.A. 52). The Plan defined a sickness as: (1) "a disturbance in function or structure of Your body"; (2) "which causes physical signs and/or symptoms and"; (3) "which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body." *Id.*

On April 6, 1992, during Barbara's annual gynecological examination, twenty-four days before the Plan's effective date, Dr. Phillips-Seitz discovered an "elongated ropey mass on the left [breast] at one o'clock." (J.A. 68-69, 74). Although Dr. Phillips-Seitz thought the newly discovered breast mass

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[2] The plaintiffs-appellees are collectively referred to as "the Hardesters."

probably was benign, she was more concerned about the possibility of cancer than she had been in April 1991 because of the marked fibrocystic change in the left breast. Accordingly, Dr. Phillips-Seitz referred Barbara to Dr. Boyle for a follow-up examination of the mass which, although presumably benign at that time, was later determined to be cancerous.

On May 1, 1992, Dr. Boyle again examined Barbara and noted the presence of the left breast mass. The mass, in the same location as the mass identified by Dr. Phillips-Seitz on April 6, 1992, was "ovoid" in shape, with a size of two centimeters by one centimeter. (J.A. 86). Initially, Dr. Boyle thought the mass was "probably" caused by fibrocystic disease. Dr. Boyle, however, admitted that when she felt the mass, she did not know whether she was feeling the fibrocystic condition or the cancerous tumor itself. Dr. Boyle recommended that Barbara have a mammogram, the results of which were negative. On May 13, 1992, Dr. Boyle again examined Barbara. Because the examination revealed no change in the condition of the breast mass, Dr. Boyle recommended a biopsy of the left breast mass. On May 28, 1992, the pathology report of the biopsy established that the mass was cancerous. Completely contained within the fibrocystic mass, the cancer itself constituted approximately one-third of the mass.

On June 15, 1992, Dr. Boyle surgically removed Barbara's left breast mass. If the cancerous mass had not been removed, it is likely that Barbara would have died from breast cancer, in the absence of intervening causes.

Barbara filed a claim for benefits under the Plan for the care and treatment she received for breast cancer. The Defendants refused to pay benefits for the treatment of the cancerous breast mass on the stated ground that it was a pre-existing condition based on "the medical records from Dr.

Phillips-Seitz dated April 6, 1992," (J.A. 101), which reflected that Barbara received treatment for the breast mass later determined to be cancerous.

On June 9, 1993, the Hardesters filed suit against the Defendants in the United States District Court for the District of Maryland.[3] The Hardesters alleged that the denial of benefits violated ERISA, 29 U.S.C. § 1132(a)(1)(B).[4]

After discovery, on October 13, 1993, the Defendants filed a motion for summary judgment. On October 26, 1993, the Hardesters filed a cross-motion for summary judgment and an opposition to the Defendants' motion. Granting the Hardesters' motion and denying the Defendants' motion, the district court reasoned:

> It is fair to say that prior to May 1, 1992, plaintiff had received medical attention for her fibrocystic disease. However, fibrocystic disease is not a "sickness" within the meaning of the policy since it would not in and of itself, if left untreated, have resulted in any deterioration of plaintiff's health. Conversely, while it may be assumed that plaintiff did have breast cancer prior to May 1, 1992—which certainly would be a "sickness" within the meaning of the policy-plaintiff had not received any "medical

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[3] The Hardesters first appealed the denial within the claims appeal process provided by the Defendants, but the companies continued to deny the claim.

[4] 29 U.S.C. § 1132(a)(l)(B) provides that: "A civil action may be brought by a participant or beneficiary . . . to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."

> attention" for it. The cancer had not been diagnosed prior to May 1, 1992, and the care, treatment, service and consultation that plaintiff had received had only been for the fibrocystic disease.

(J.A. 156). The district court proceeded to hold that the simultaneous occurrence of the fibrocystic disease and the cancerous mass was coincidental. Accordingly, the district court concluded, "It would, at the least, distort th[e] purpose [of a pre-existing condition exclusion] to hold that a beneficiary has a 'pre-existing condition' within the meaning of the clause if she does not know or have reason to know of the existence of the condition." (J.A. 157).[5] Therefore, on January 7, 1994, the district court issued a memorandum and order denying the Defendant's motion for summary judgment, granting the Hardesters' cross-motion for summary judgment, and entering judgment as a matter of law in favor of the Hardesters. This appeal followed.

II

The standard of appellate review for the granting or denial of a summary judgment motion is *de novo*. Thus, the court of appeals uses the same standard as the district court. A moving party is entitled to summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to material fact and that the moving party is

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[5] Dr. Boyle sent a letter to Lincoln National advising it that the "routine preventive health maintenance checkup by her [Mrs. Hardester's] gynecologist in April 1992" was not medical attention for a sickness as defined in their policy. The letter said that the consultation referral was for a fibrocystic condition and "could hardly be construed as treatment for carcinoma of the breast." (J.A. 145-46).

entitled to judgment as a matter of law." Fed. R. Civ. Pro. 56(c). *See Charbonnages de France v. Smith*, 597 F.2d 406 (4th Cir. 1979).

A genuine issue exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). In considering a motion for summary judgment, the court is required to view the facts and draw reasonable inferences in a light most favorable to the nonmoving party. *Id.* at 255. The plaintiff is entitled to have the credibility of all her evidence presumed. *Miller v. Leathers*, 913 F.2d 1085, 1087 (4th Cir. 1990), *cert. denied*, 111 S. Ct. 1018 (1991). The party seeking summary judgment has the initial burden to show absence of evidence to support the nonmoving party's case. *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). The opposing party must demonstrate that a triable issue of fact exists; it may not rest upon mere allegations or denials. *Anderson*, 477 U.S. at 248. A mere scintilla of evidence supporting the case is insufficient. *Id.*

Likewise, court actions challenging the denial of benefits under 29 U.S.C. § 1132(a)(1)(B) are subject to the standard of review announced in *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101 (1989). Pursuant to that standard, the district court in the instant case reviewed the denial of benefits *de novo*. (J.A. 154-55 & n.2). We also review the denial of benefits *de novo*. *See Firestone*, 489 U.S. at 115; *Quesinberry v. Life Ins. Co. of N. Am.*, 987 F.2d 1017, 1021 (4th Cir. 1993) (en banc).

III

This case is governed by ERISA, which requires us to apply federal common law rules of contract interpretation when interpreting the terms of an employee health insurance policy. *Hammond v. Fidelity and Guar. Life Ins. Co.*, 965 F.2d 428,

430 (7th Cir. 1992). *See Thompson v. Talquin Bldg. Products Co.*, 928 F.2d 649 (4th Cir. 1991). In interpreting an ERISA plan, a court should "view the language of the insurance policy to determine where the parties' minds met." *Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429, 432 (7th Cir. 1994). Therefore, we must give effect to the words which denote the bargain, "not in light of public policy considerations, but in light of their plain meaning." *Id.* We have held that "[c]ourts are not at liberty to disregard the plain language of a plan in order to demand that insurers provide coverage . . . ." *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 57 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 1051 (1993). In the absence of any ambiguity, our inquiry is limited to the terms and conditions set forth in the written Plan. *Id.* at 56. *See International Union of Electronic, Elec., Salaried, Mach. and Furniture Workers, AFL-CIO v. Murata Erie North America, Inc.*, 980 F.2d 889, 907 (3d Cir. 1992).

Applying the above guidelines, we must determine whether the undiagnosed breast cancer constituted a: (1) sickness within the meaning of the Plan (2) for which Barbara had received medical attention such that the pre-existing condition exclusion under the Plan prevented her from collecting insurance benefits.

Examination of the plain language of the policy reveals that the pre-existing condition exclusion works to deny coverage in the instant case. Barbara's breast cancer falls within the Plan's specific definition of a sickness for which she received medical attention.

The Plan defined "sickness" as (1) "a disturbance in function or structure of Your body"; (2) "which causes physical signs and/or symptoms and"; (3) "which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body." (J.A. 52). With

regard to the first element of "sickness," although the Plan does not define the term "disturbance", an ERISA plan must be interpreted according to the understanding of a reasonable layperson. *Senkier v. Hartford Life & Acc. Ins. Co.*, 948 F.2d 1050, 1052-53 (7th Cir. 1991). *See Hammond*, 965 F.2d 428 ("we interpret the terms of the policy 'in an ordinary and popular sense as would a [person] of average intelligence and experience.'") (citations omitted). The ordinary meaning of "disturbance" is an "alteration." *Webster's Third New Int'l Dictionary* (1981). A breast mass certainly constitutes an alteration of the "structure of the body." Moreover, we believe that a person of average intelligence would understand a breast mass to constitute a disturbance in body structure. Therefore, the first requirement under the definition of sickness has been fulfilled.

On April 6, 1992, the breast mass could be felt; therefore, it exhibited a clear "physical sign"—the second requirement for a "sickness."[6] The Hardesters argue that the fibrocystic breast disease caused the "sign" or "symptom" and not the cancer. We cannot accept that argument. Although the fibrocystic disease may well have caused the largest part of the mass, a portion of the lump contained within the mass was later determined to be cancerous. Further, it does not appear that the fibrocystic disease and the cancerous mass were as "coincidental" and "separable" as the district court stated. In fact, Dr. Boyle, in her deposition, admitted that when she was feeling the mass, she was not sure whether she was touching the fibrocystic condition or the cancerous lump itself.

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[6] It is also apparent that the Plan's definition of a "sickness" did not require that the breast cancer be accurately diagnosed before the effective date.

Finally, we address the third element of a "sickness." A portion of the mass was discovered to be cancerous. If left untreated, the mass would have caused a "deterioration" in the "state" of Barbara Hardester's health: as Dr. Phillips-Seitz testified, she would have died.

Next, we turn to whether, within the twenty-four months prior to May 1, 1992, Barbara received "medical attention" for her breast mass which was later diagnosed as cancerous. The Plan defines medical attention as any one of the following: (1) care; (2) treatment; (3) services; (4) medication; (5) diagnosis; or (6) consultation. In the instant case, Barbara received "care," "treatment," "services," or "consultation" for or relating to the breast mass which a later biopsy revealed to have been malignant: Dr. Phillips-Seitz discovered the breast mass on April 6, 1992 and noted it in her medical record. Although she still believed the mass was merely fibrocystic in nature, the marked fibrocystic change in the left breast had heightened Dr. Phillips-Seitz's concern over the possibility of cancer. As a precaution, she referred Barbara to Dr. Boyle, who performed the biopsy.[7] The results of the biopsy established that the lump previously thought to be benign was actually a cancerous mass contained within the fibrocystic mass. Because the lump was cancerous on May 28, 1992, we may infer that the lump was cancerous on April 6, 1992. In fact, the district court held that "it may be assumed that plaintiff [Barbara] did have breast cancer prior to May 1, 1992." (J.A. 156). Therefore, although Barbara was unaware that "the lump was cancerous in April, her visit with the doctor in that month concerning the lump actually concerned cancer." *Bullwinkel*, 18 F.3d at 432. It follows that Barbara

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[7] The Defendants point out that the original diagnosis of the breast mass, although erroneous, was medical attention *per se*.

received "care," "treatment," "services," and "consultation" in April for her cancer.

We find further support for our conclusion in the decisions of two other circuits which have considered the specific issue presented by the instant case. In *Bullwinkel*, the Seventh Circuit held that a preexisting condition exclusion applies to an undiagnosed illness. The facts of that case are substantially similar to the facts in the case at hand. In *Bullwinkel*, Mrs. Bullwinkel had detected a lump in her left breast. 18 F.3d at 429-30. She saw her physician on July 20, 1991, and he performed an ultrasound examination of the lump. The physician diagnosed the lump as a cyst and assured her that the cyst was probably benign. Because he was concerned about the possibility of cancer, however, Mrs. Bullwinkel's physician referred her to a surgeon for removal and biopsy of the cyst. *Id.*

The New England Mutual Policy became effective on July 31, 1991. Mrs. Bullwinkel had her first visit to the surgeon on August 15; the surgeon removed the lump on September 6, 1991. Tests on the removed lump revealed that it was cancerous. *Id.*

Mrs. Bullwinkel sought coverage from New England Mutual for her initial surgery and subsequent cancer treatment. New England Mutual denied coverage based on the pre-existing condition exclusion.[8] Both the district court and

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[8] The pre-existing condition exclusion, nearly identical to the exclusion in the instant Plan, provided in pertinent part as follows: "No benefits are payable for a condition, sickness, or injury for which you or your dependent were seen, treated, diagnosed, or incurred medical expense in the six-month period just before insurance starts . . . ." *Id.* at 431.

the Seventh Circuit affirmed the denial of benefits. The Seventh Circuit explained its decision:

> True, Madeline was never "seen, treated, [or] diagnosed" specifically for breast cancer in July, nor did she incur medical expenses specifically for breast cancer in July. But she was "seen, treated, [and] diagnosed" and she did incur medical expenses for a breast lump in July. The lump was discovered in September to be cancerous. We may infer from this fact that the lump was also cancerous in July. So, even though Madeline did not know the lump was cancerous in July, her visit with the doctor in that month concerning the lump actually concerned cancer. It follows that Madeline was "seen" and "treated" and incurred medical expenses for her cancer in July. Therefore, any post-policy treatment concerning the same condition is not covered.

Id. at 432.[9]

In light of the principles set forth in the above cases, we agree with the positions taken by the Seventh and Eighth

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[9] The Eighth Circuit also adheres to the view expressed in *Bullwinkel*. In *Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504 (8th Cir. 1991), Kirk was treated for a number of symptoms which led his physician to suspect he had a congenital heart disease. A blood test that should have detected the disease, however, proved negative. *Id.* at 505-06. Kirk then became a member of an ERISA health care benefit plan that excluded pre-existing conditions. When Kirk later displayed symptoms of congenital heart disease, a heart specialist diagnosed his condition as a heart illness. *Id.* at 506. The Eighth Circuit found Kirk's illness was not covered because his illness predated the policy. The *Kirk* court was unpersuaded by the fact that the illness was not diagnosed until after the policy became effective. *Id.*

Circuits and find that the pre-existing condition exclusion in the instant case precludes any recovery for medical expenses regarding Barbara's breast cancer. First, as the decisions above indicate, simply because Barbara's cancer was not yet diagnosed at the Plan's effective date does not mean that she did not have a pre-existing condition: Barbara received "medical attention" [as defined in the Plan] for a sickness within the meaning of the Plan. For example, Barbara, like the plaintiff in *Bullwinkel*, saw her physician shortly before the Plan's effective date. Her physician found a breast mass. Dr. Phillips-Seitz, like Mrs. Bullwinkel's physician, was concerned about the possibility that the mass might be cancerous and referred her to a surgeon as a precaution. As a result of the referral, a biopsy was performed, and, like Mrs. Bullwinkel, Barbara's breast mass was determined to be cancerous. We conclude that, as in Mrs. Bullwinkel's case, Barbara received medical attention for her cancer before the Plan's effective date.

The Hardesters contend that the pre-existing condition exclusion does not prevent coverage of the breast cancer. We disagree. The Hardesters argue, that, as the district court noted, not requiring specific knowledge of the illness would allow insurers to avoid coverage "when the victim is blissfully unaware of the medical 'seeds' visited upon his body." (J.A. 157) (quoting *Mutual Hosp. Ins., Inc. v. Klapper*, 288 N.E.2d 279, 282 (Ind. Ct. App. 1972) (reversing summary judgment entered in favor of the insured in a non-ERISA case)).[10]

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[10] We note that the *Klapper* case is a pre-ERISA case based on Indiana state law which is factually distinguishable from the instant case. In *Klapper*, the medical attention occurred after the effective date of the policy, and the *Klapper* court merely considered the question of when an illness "exists." That case is simply not analogous to the instant case.

While we acknowledge that this argument is emotionally appealing, we are constrained to reject it. As the Seventh Circuit stated in *Bullwinkel*, interpretation of an insurance contract requires that we look to the language of the insurance contract—not public policy:

> The Bullwinkels commit a large portion of their brief to making public policy arguments favoring their position. But we are restricted by federal common law rules of contract interpretation to view the language of the insurance policy to determine where the parties' minds met. Therefore, we must give effect to the words which denote the bargain, not in light of public policy considerations, but in light of their plain meaning.

Bullwinkel, 18 F.3d at 431. The plain language of the policy at issue indicates that Barbara's breast cancer was a pre-existing condition excluded from coverage under the Plan.

IV

In summary, we find that the district court erred in denying the Defendants' motion for summary judgment and in granting the Hardesters' cross-motion for summary judgment. Accordingly, for the reasons stated herein, the judgment of the district court is reversed and the case is remanded with instructions to enter judgment for the Defendants.[11]

REVERSED AND REMANDED WITH INSTRUCTIONS

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[11] We hereby grant the Hardesters' motion to strike the Addendum of Secondary Authority appended to the Defendants' brief as well as any reference to the addendum and similar authority contained within the brief.

HALL, Circuit Judge, dissenting:

According to Dr. Phillips-Seitz, "we were lucky to have found this elongated ropey mass . . . because otherwise we wouldn't have noticed the cancer." Today the majority turns Mrs. Hardester's luck into the insurance companies'. There are times when the law compels such an unjust result, but not this time. I dissent.

I.

Plaintiff Barbara Hardester was diagnosed with fibrocystic breast disease in 1982. This "disease" is wholly benign, and is common in women in their thirties and forties. A woman suffering from fibrocystic disease will develop cysts, masses, and other accumulations of fibrous tissue in her breasts. Fibrocystic disease *is not* cancer, and *does not develop* into cancer; indeed, it does no damage to the woman's physical health at all.

On April 6, 1992, Mrs. Hardester had her annual gynecological examination. Her gynecologist, Dr. Phillips-Seitz, noted fibrocystic changes from the previous year in both breasts and an "elongated ropey mass" in the left breast. As she always did when she noted any new manifestation of the fibrocystic disease—indeed, as she had the previous year—Dr. Phillips-Seitz referred Mrs. Hardester to a surgeon, Dr. Boyle, for follow-up.[1]

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[1] At her deposition, Dr. Phillips-Seitz testified that she refers "anybody with a fibrocystic condition" to a surgeon, but that those referrals uncovered latent breast cancer less than five percent, "maybe one percent" of the time. Where Dr. Phillips-Seitz actually *suspects* cancer, she refers her patient to a surgeon within a day, rather than the several weeks for an ordinary referral.

Dr. Boyle saw Mrs. Hardester on May 1, the day she first became insured under the policy. Dr. Boyle diagnosed fibrocystic disease as well. In addition, because of the fibrocystic changes and because it had been more than a year since Mrs. Hardester's last mammogram, Dr. Boyle ordered a mammogram. The mammogram, performed May 7, was negative.

Mrs. Hardester returned to Dr. Boyle on May 15 as a follow-up to the mammogram. Because mammograms are less accurate for women with dense fibrous breast tissue, Dr. Boyle recommended a biopsy of the mass in the left breast. The "elongated ropey mass" was removed on May 26, and the results of a biopsy were returned on June 3. Most of the mass was fibrocystic tissue; however, it contained a small (9 mm across) malignant carcinoma. That the fibrocystic "ropey mass" happened to encase the unrelated cancer had saved Mrs. Hardester's life. Dr. Phillips-Seitz explained, "we were lucky to have found this elongated ropey mass . . . because otherwise we wouldn't have noticed the cancer. If she had simply had this tiny cancer in her breast, we wouldn't have felt it." Dr. Boyle likewise described the cancer as merely "coincident" with the fibrocystic disease, with no causal connection.

Though the carcinoma itself was removed before it was even discovered, Mrs. Hardester had to undergo chemotherapy to prevent recurrence of breast cancer. Lincoln National and Employers Health have refused to pay for this vital treatment because they assert that the cancer was a "preexisting condition" under the policy. After she exhausted the companies' internal remedies, Mrs. Hardester, along with her husband (the named insured), filed this suit in district court. The district court conducted a de novo review of the record, found that Mrs. Hardester's breast cancer was not a "preexisting condition," and ordered the insurance companies

to pay. *Hardester v. Lincoln National Life Insurance Co.*, 841 F. Supp. 714 (D. Md. 1994).

The insurance companies appeal.

II.

Review here, as in the district court, is de novo. *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989). In interpreting the policy, we apply ordinary principles of contract law. *Glocker v. W. R. Grace and Co.*, 974 F.2d 540, 544 (4th Cir. 1992). These principles require us to enforce the policy's plain language in its ordinary sense and to construe ambiguous terms against the drafter if they are not clarified by extrinsic evidence of the parties' intent. *Id.*

For the first year following the effective date of coverage, the insurance policy at issue does not cover a "preexisting condition":

> a Sickness or Bodily injury for which You have received medical attention (care, treatment, services, medication, diagnosis or consultation) prior to [the effective date].

A "Sickness" is

> a disturbance in the function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body.

I agree with the district court that Mrs. Hardester's breast cancer was not a "preexisting condition" under these clauses. The medical record shows that Mrs. Hardester went for a *routine* annual gynecological exam and received a *routine* referral to a surgeon for follow-up on the new manifestations of her fibrocystic disease. She received absolutely no "care,

treatment, services, medication, diagnosis or consultation" for the tiny carcinoma in her breast before the effective date of the policy.

Lacking evidence, the insurance companies resort to distortion of the record and of the district court's opinion. Their most pervasive gimmick is to absolutely ignore a fact undisputed in this record—the large ropey fibrocystic mass and the small carcinoma were merely, and luckily, *coincident*. From the very beginning of their brief's "Statement of the Case," the insurance companies refer to "the mass" as if a single condition were involved.[2] Through this distortion, the companies are then able to make arguments that "the mass" had "caused physical signs or symptoms" and had received "medical attention" before the effective date of the policy. The companies have convinced the majority to look at the case this way,[3] but they have not convinced me.

Most of "the mass" was just what Dr. Phillips-Seitz thought it was—benign fibrous tissue. The tumor, on the other hand, would not have been palpable to Dr. Phillips-Seitz[4] but

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[2] *E.g.*, under "Nature of the Case," the companies assert:

> The gynecologist erroneously believed the mass was benign. One month after the effective date, the breast mass was conclusively diagnosed as cancerous.

[3] *See supra* at 7-9, where the majority applies the policy's preexisting condition test to "the mass" rather than to the cancer.

[4] The majority cites *Dr. Boyle's* deposition testimony (*supra* at 8) in an attempt to show that, perhaps, the carcinoma itself was palpable. I see no relevance in what Dr. Boyle felt or did not feel after the effective date of the policy. Dr. Phillips-Seitz stated that she could not have felt the tiny cancer on April 6, which is the only

(continued...)

for the "lucky" happenstance that it was encased in unrelated benign tissue. The tumor *had not* caused any noticeable physical change or symptom in Mrs. Hardester before the effective date of the policy, and it had not received any medical attention.

The best way to illustrate is to hypothesize a woman precisely like Mrs. Hardester *except* that she did not suffer from fibrocystic disease. On April 6, she would have had a routine, normal breast exam; because the tumor was too small to be felt, she would not have been referred to Dr. Boyle for follow-up, and may not have had a mammogram or biopsy for several months or years. When she was finally diagnosed with cancer, could the insurance companies assert that she had received "medical attention" for her cancer on April 6? Of course not. Why, then, should the result be any different just because Mrs. Hardester had a benign, unrelated condition that was treated on April 6 and that, through sheer luck, led to the timely discovery of her cancer? The answer is simple: it should not make any difference.

I reiterate: *according to the undisputed medical record, there was no causal or associative relationship between the fibrocystic tissue and the carcinoma.* What if Dr. Boyle's follow-up had uncovered cancer in Mrs. Hardester's other breast, and nothing but fibrocystic tissue in the "elongated ropey mass?" Could the insurance companies assert that she had received "medical attention" for cancer on April 6? I would hope that all persons of good will would answer, "Of

---

[4] (...continued)
possible date the cancer could have received "medical attention" before the policy went into effect.

course not."[5] Why, then, should the result be any different just because Mrs. Hardester had a benign, unrelated condition that was treated on April 6 and that, through sheer luck, led to the timely discovery of her cancer? The answer is simple: it should not make any difference.

The companies' best case is *Bullwinkel v. New England Mutual Life Insurance Co.*, 18 F.3d 429 (7th Cir. 1994). *Bullwinkel* involved, as the companies wish this case did, a single, suspicious "lump," discovered just before the effective date of the policy. The doctor felt *at the time* that "the lump" was more likely than not benign, but he was concerned about "the possibility" of cancer. The lump was later removed and was found to be malignant. The Seventh Circuit held that the cancer was preexisting, and that the lack of a definite diagnosis was irrelevant.

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[5] Nonetheless, the logical extension of the insurance companies' argument here would call for a contrary answer. According to their brief, any referral for testing motivated by a desire to rule out breast cancer is "medical attention" for cancer under the Plan. This argument badly distorts the manner in which preventive care is administered to women in this country. *Every* woman must be concerned about and take precautions against breast cancer. Physicians like Drs. Phillips-Seitz and Boyle order mammograms and other diagnostic tests routinely, not because the risk to any single woman is very great, but because the risk is there in every woman, and the consequence of not taking routine precautions is so dire. A doctor who ignores a one percent risk of death present in all of her patients can be assured that several will die every year. On the other hand, the dead patients' insurance companies would not have any "precautions" to point to as evidence of a "preexisting" condition. Excuse me for using the law's most hackneyed literary allusion, but a medical insurance system that covers only well persons and those sick persons who have not vigilantly monitored their health makes sense only if viewed through the looking glass.

I am not sure that I agree with *Bullwinkel*, but I can say that it is easily distinguishable from this case. Here, the cancer was discovered *in the course of treating an unrelated manifest condition*, while in *Bullwinkel* the only issue was whether the manifest condition was or was not malignant. In other words, the cancerous lump was discovered before the effective date in *Bullwinkel*; here, the cancerous lump was discovered *after* the effective date.[6]

Finally, the companies assert that Judge Motz "held" that applying a preexisting condition clause to an undiagnosed condition would violate public policy. He did no such thing. He held that Mrs. Hardester's cancer was not preexisting under the clause at issue, and, because "the case can be decided on its own narrow facts[,] I need not decide the broader question which it poses." Judge Motz then went on to question whether public policy would permit the enforcement of a preexisting condition clause, like the one here, that wholly dispenses with a requirement that the patient know (or have reason to know) of his condition on the effective date of the policy. He quoted an Illinois case: "'to consider a disease to exist at a time when the victim is blissfully unaware of the medical "seeds" visited upon his body, is to set a trap for the unwary purchaser of health insurance policies.'" 841 F. Supp. at 716 (*quoting Mutual Hospital Ins., Inc. v. Klapper*, 288 N.E.2d 279, 282 (Ill. App. 1972)). I share the concerns of Judge Motz, but, just as he resolved the case in Mrs. Hardester's favor on the terms of the clause, so also would I.

I respectfully dissent.

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[6] My comment on *Kirk v. Provident Life and Accident Insurance Co.*, 942 F.2d 504 (8th Cir. 1991), is simply that I agree with Senior Judge Bright's dissent in that case. *Id.* at 506-508.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

ALAN L. HARDESTER, JR. AND BARBARA HARDESTER	*	
	*	
v.	*	Civil No.
	*	JFM-93-1685
LINCOLN NATIONAL LIFE INSURANCE COMPANY AND EMPLOYERS HEALTH INSURANCE COMPANY	*	

*****

MEMORANDUM

This case arises out of the denial of Barbara Hardester's (hereinafter plaintiff) health insurance claim for coverage of medical expenses following the diagnosis and treatment of her breast cancer. Plaintiff's insurers, Lincoln National Life Insurance Company and its subsidiary Employers Health Insurance Company (hereinafter defendants), refused to pay plaintiff's claim, asserting that the breast cancer was a pre-existing condition and was thus excluded from coverage under plaintiff's policy.

I.

Plaintiff procured her health insurance from defendants as an eligible family member under a group policy provided by her husband's employer. The effective date of plaintiff's coverage was 12:01 a.m. on May 1, 1992.

In 1981, plaintiff was first diagnosed with fibrocystic breast disease. Fibrocystic breast disease (also known as fibrocystic changes) is a common condition in women in their thirties and forties. It manifests itself by the appearance of benign cysts, masses, and formations of fibrous tissue in the breasts. Despite its characterization as a "disease," the condition is not one which in and of itself causes any deterioration in health. Fibrocystic breast disease does not develop into cancer.

On April 6, 1992, approximately a month before her health insurance coverage commenced, plaintiff had a routine gynecological examination. Her gynecologist, Dr. Barbara Phillips-Seitz, noted the presence of fibrocystic changes in both her breasts and an "elongated ropey mass" in her left breast. Dr. Phillips-Seitz diagnosed this mass as a fibrocystic condition but, as a precaution, referred plaintiff to Dr. Mary Boyle for a follow-up examination of plaintiff's left breast. Dr. Boyle examined plaintiff on May 1, 1992, concluded that plaintiff had fibrocystic disease, and recommended that plaintiff get a mammogram and then return for another follow-up.[1] Plaintiff's mammogram, which was performed on May 7, was negative. On May 15, plaintiff returned to Dr. Boyle's office. Dr. Boyle removed a mole from plaintiff's breast and recommended a biopsy of the mass in her left breast. The mass was biopsied on May 26, and on June 3 the pathology report of the biopsy indicated that cancerous tissue was present in the mass. Plaintiff subsequently underwent surgery and chemotherapy to combat the breast cancer.

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[1] On deposition Dr. Boyle testified that she would have recommended that plaintiff have a mammogram whether or not the presence of the fibrocystic changes had been noted since it had been more than a year since plaintiff had had a mammogram.

Plaintiff submitted a claim to defendants seeking coverage under the group policy for the medical expenses incurred in the treatment of her breast cancer. On August 27, defendants denied her claim on the basis that the breast cancer was a pre-existing condition and was thus not covered by the policy. Using defendants' internal review mechanisms, plaintiff appealed defendants' decision several times, each time resulting in a denial of the claim. Plaintiff then filed an administrative complaint against defendants with the Maryland Insurance Division (MID). Defendants responded to the MID, affirming their decision to deny coverage to plaintiff. Plaintiff then initiated this action under the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132(a)(1)(B). After a brief period for discovery, parties made the cross-motions for summary judgment that are now before this court.

II.

Plaintiff alleges that defendants' denial of benefits violates ERISA, 29 U.S.C. § 1132(a)(1)(B). ERISA empowers participants in an employee benefit plan to bring a civil action in federal court to enforce their rights under the terms of the plan. The parties agree that this court should review defendants' denial of benefits *de novo*. *See generally Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989).[2]

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[2] Although a court should ordinarily limit its review to the evidentiary record available to the plan administrator, it may in "exceptional circumstances" consider additional evidence. *Quesinberry v. Life Ins. Co.*, 987 F.2d 1017, 1026. (4th Cir. 1993). "Exceptional circumstances" include "claims that require the consideration of complex medical questions . . . [or] the necessity of evidence regarding interpretation of the terms of the plan rather than specific historical facts." *Id.* at 1027. Here, the parties seem

(continued...)

Plaintiff's policy does not provide medical benefits for pre-existing conditions. The policy defines a "pre-existing condition" as:

> a Sickness or Bodily Injury for which You have received medical attention (care, treatment, services, medication, diagnosis or consultation) prior to: 1. The effective date of Your medical or loss of time coverage under this Policy. . . .

A "sickness" is defined as:

> a disturbance in the function or structure of Your body which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body.

Def. SUMF, ¶¶ 8, 9. Therefore, the question presented in this case is whether prior to May 1, 1992 plaintiff had received "medical care, treatment, services, medication, diagnosis or consultation" for "a disturbance in the function or structure of . . . [her] body . . . which, if left untreated, . . . [would have] result[ed] in a deterioration of the health state of the structure or system[s] of . . . [her] body."

The record establishes that she had not. It is fair to say that prior to May 1, 1992, plaintiff had received medical attention for her fibrocystic disease. However, fibrocystic disease is not a "sickness" within the meaning of the policy since it would not in and of itself, if left untreated, have

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[2] (...continued)
implicitly to agree that exceptional circumstances exist since they engaged in discovery and have both cited to depositions of physicians. In any event, the substance of the evidence before me was equally before defendants when they denied plaintiff's claim.

resulted in any deterioration of plaintiff's health. Conversely, while it may be assumed that plaintiff did have breast cancer prior to May 1, 1992-which certainly would be a "sickness" within the meaning of the policy-plaintiff had not received any "medical attention" for it. The cancer had not been diagnosed prior to May 1, 1992, and the care, treatment, service and consultation that plaintiff had received had only been for the fibrocystic disease.

Defendants seek to join the two distinct conditions of fibrocystic disease and cancer together by arguing that plaintiff had received medical attention for a mass in which the cancer and fibrocystic changes were both located. However, the undisputed medical record establishes that the simultaneous occurrence of the two conditions was coincidental. Moreover, the record further establishes that the "mass," i.e., the palpable and detectable condition, was caused by the fibrocystic changes and that although the cancer constituted approximately one-third of the mass, it would not alone have been observable.[3]

Under these circumstances it is clear that plaintiff is entitled to the health benefits that she seeks. Since the case

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[3] The fact that prior to May 1, 1992 plaintiff was being treated for fibrocystic disease rather than for cancer is confirmed by Dr. Phillips-Seitz' contemporaneous actions. After she examined plaintiff on April 6, 1992, Dr. Phillips-Seitz arranged for plaintiff to be seen by Dr. Boyle more than three weeks later. This was because Dr. Phillips-Seitz believed that there was only a very small chance (which Dr. Phillips-Seitz quantified at deposition to be between one and five percent) that plaintiff had cancer. If Dr. Phillips-Seitz had been of the view that there was any substantial likelihood that plaintiff had cancer, she would have, according to her deposition testimony, arranged for plaintiff to be seen by a surgeon on that day or the next day.

can be decided on its own narrow facts, I need not decide the broader question which it poses. The purpose of pre-existing condition clauses is to protect "insurers from fraudulent applicants seeking coverage for known diseases while protecting innocent premium paying insureds from being deprived of benefits for pre-existing conditions of which they have no knowledge." *Mogil v. California Physicians Corp.*, 267 Cal. Rptr. 487, 491 (Cal. App. 1990). *Accord*, 10A *Couch on Insurance 2d*, § 41A:13 (stating that the purpose of the clause is to "shelter the insurer from claims arising out of conditions existing and known by the insured prior to the inception of the policy."); *Scarborough v. Aetna Life Ins. Co.*, 572 S.W. 2d 281, 284 (Tex. 1978) ("for the exclusion to apply it is necessary that the insured received a medical service (which may be a preliminary examination) directed towards a *known* condition."). It would, at the least, distort this purpose to hold that a beneficiary has a "pre-existing condition" within the meaning of the clause if she does not know or have reason to know of the existence of the condition. As one court has stated, "to consider a disease to exist at a time when the victim is blissfully unaware of the medical 'seeds' visited upon his body, is to set a trap for the unwary purchaser of health insurance policies." *Mutual Hosp. Ins. Inc. v. Klapper*, 288 N.E. 2d 279, 282 (Ill. App. 1972).[4]

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[4] To dispense with the requirement of knowledge is so perverse that even if a pre-existing condition clause expressly voided coverage for unknown conditions, it might be unenforceable as a matter of public policy. Certainly, in light of the common law doctrine of *contra proferentum, see generally Glocker v. W.R. Grace & Co.*, 974 F.2d 540 (4th Cir. 1992); *Phillips v. Lincoln Nat. Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104 (8th Cir. 1992); *Masella v. Blue Cross & Blue Shield Inc.*, 936 F.2d 98 (2nd Cir. 1991), a court would be reluctant to construe a

(continued...)

A separate order effecting the rules made in this memorandum is being entered herewith.

Date: _____ _____

J. Frederick Motz
United States District Judge

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[4] (...continued)
pre-existing condition clause that is not explicit in not requiring knowledge or its equivalent.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT FOR THE DISTRICT OF MARYLAND

ALAN L. HARDESTER, JR. AND BARBARA HARDESTER	*	
	*	
v.	*	Civil No.
	*	JFM-93-1685
LINCOLN NATIONAL LIFE INSURANCE COMPANY AND EMPLOYERS HEALTH INSURANCE COMPANY	*	

*****

ORDER

For the reasons stated in the memorandum entered herein, it is this 7th day of January 1994

ORDERED

1. Defendants' motion for summary judgment is denied;

2. Plaintiffs' motion for summary judgment is granted; and

3. Judgment is entered in favor of plaintiffs against defendants.

J. Frederick Motz
United States District Judge

APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

FILED
October 13, 1994

No. 94-1172

CA-93-1685-JFM

ALLEN L. HARDESTER, JR.; BARBARA HARDESTER

Plaintiffs - Appellees

v.

THE LINCOLN NATIONAL LIFE INSURANCE COMPANY, administrator; EMPLOYERS HEALTH INSURANCE COMPANY

Defendants - Appellants

On Petition for Rehearing with Suggestion for Rehearing In Banc

The appellees' petition for rehearing and suggestion for rehearing in banc were submitted to the Court. A majority of judges having voted in a requested poll of the Court to grant rehearing in banc,

IT IS ORDERED that the rehearing in banc is granted.

IT IS FURTHER ORDERED that this case shall be calendared for argument at the March 1995 session of Court. Within ten days of the date of this order, 15 additional copies of appellants' brief; 15 additional copies of appellees' brief; and 15 copies of the appellants' reply brief shall be filed. Appellees will file 18 additional copies of the joint appendix.

For the Court,

/s/ Bert M. Montague
CLERK

Supreme Court, U.S.
FILED
AUG 14 1995
OFFICE OF THE CLERK

No. 95-66

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

LINCOLN NATIONAL LIFE INSURANCE COMPANY and
EMPLOYERS HEALTH INSURANCE COMPANY,
Petitioners,
v.
ALLEN L. HARDESTER, JR. and BARBARA HARDESTER,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-66

LINCOLN NATIONAL LIFE INSURANCE COMPANY and
EMPLOYERS HEALTH INSURANCE COMPANY
Petitioners,
v.
ALLEN L. HARDESTER, JR. and BARBARA HARDESTER
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

The Health Insurance Association of America ("HIAA") submits this brief in support of the Petition of Lincoln National Life Insurance Company and Employers Health Insurance Company (collectively, "Lincoln National") for a writ of certiorari in this case. Both the Petitioners and the Respondents have consented to the filing of this brief. Correspondence confirming such consent has been filed with the Clerk of this Court.

INTEREST OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

The HIAA submits this brief to support the interests of its members and other parties with a stake in the viability and affordability of group health insurance contracts governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001-1461. The HIAA is the largest health insurance trade association in the United States and represents the interests of approximately 230 member companies, including many of the leading health insurers in this country. HIAA members currently provide health insurance coverage to over fifty million Americans, many of whom are participants in and beneficiaries of ERISA-regulated benefit plans.

The Fourth Circuit Court of Appeals' *en banc* decision in this matter is of great concern to the HIAA and its members because it undermines the intended operation of preexisting condition provisions contained in the vast majority of health insurance contracts issued in the United States. By negating the force and effect of a standard preexisting condition provision, the Fourth Circuit's decision renders meaningless the actuarial assumptions on which the Petitioners in this case — and indeed virtually all commercial health insurers — rely in issuing health insurance contracts. In short, the Fourth Circuit's erroneous interpretation of a standard contractual provision will require Lincoln National to assume obligations not contemplated at the time the subject contract was issued. If allowed to stand, the Fourth Circuit's decision similarly could undermine ERISA-governed contracts across the board.

As a trade association for this nation's commercial health insurers, the HIAA also is concerned about the effect of the Fourth Circuit's decision on its members' relationships with the other principal ERISA entities: employers who sponsor group health plans, and the participants and beneficiaries of those plans. If left unchecked, the Fourth Circuit's decision ultimately will filter down to employers, who will be asked to pay higher premiums to re-

flect an increase in potential liability for claims formerly excluded under standard preexisting condition provisions. As with most products, these increased costs will be passed on to the ultimate "consumers," ERISA plan participants and beneficiaries, who either will be required to contribute a greater percentage of premium costs or will see a decline in available benefits in order to restrain plan costs. In a highly competitive market in which employers strenuously attempt to obtain employee health care coverage at the lowest possible cost, it is clear that by saddling commercial health insurers with unanticipated liability for claims involving preexisting conditions, the Fourth Circuit's decision will cause all players in the employee benefits arena to carry an increased burden in the ongoing battle to contain health care costs.

The HIAA submits that the ramifications of the Fourth Circuit's decision in this case extend well beyond the interests of the immediate parties and, therefore, urges this Court to grant the Petition for a Writ of Certiorari.

REASONS FOR GRANTING THE WRIT

The Fourth Circuit's decision in this case warrants review by this Court not only because it evinces a fundamental misapprehension of the proper construction of express terms of ERISA-governed group insurance contracts, but also because the decision presages a significant shift in the risks and costs associated with ERISA plans generally.

In its decision, the Fourth Circuit essentially held that the preexisting condition exclusion contained in Lincoln National's contract may be enforced only if an accurate diagnosis of the precise condition is rendered prior to a participant or beneficiary's effective date of coverage. Pet.App. 23a-26a.[1] This conclusion is clearly at odds with both the plain language of the provision itself and the holdings

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[1] References to the Appendix to Petitioners' Petition for a Writ of Certiorari, filed with this Court on July 14, 1995, are designated "Pet. App."

reached by two other Circuit Courts of Appeal addressing similar provisions contained in ERISA-governed plans. *See Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429 (7th Cir. 1994); *Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504 (8th Cir. 1991). The court's conclusion violates established, fundamental principles guiding the interpretation and construction of ERISA plan terms. The legal deficiencies in the Fourth Circuit's holding, however, pale in comparison to the deleterious effect the decision undoubtedly will have on the intended recipients of ERISA's protections.

The decision below will substantially increase the risks assumed by commercial health insurers for healthcare coverage provided to the participants and beneficiaries of ERISA-regulated benefit plans. If required to provide benefits for medical expenses historically excluded from coverage, health insurers will have no choice but to increase the cost of coverage to meet the newly-imposed liabilities, or decrease other previously-available types or amounts of benefits. These adjustments ultimately will filter down through employers and come to rest on the shoulders of ERISA plan participants and beneficiaries.

The decision below also will have a negative effect on two important goals of ERISA: the promotion of employer-provided welfare benefit plans, and the safeguarding of plan assets in the interests of all plan participants and beneficiaries. The financial integrity of ERISA plans is crucial to the proper functioning of an employer-based health care benefits system; if that integrity is shaken by unforseen liabilities like those at issue here, the entire system will feel the effect. Moreover, as in any environment involving allocation of a fixed commodity (in this case, health care), the distribution of ERISA plan benefits must be accomplished with a view toward the continuation and maintenance of the plan itself. The Fourth Circuit's ruling in this case fails to balance the interests of the individual claimant against those of all other plan participants and beneficiaries.

The Fourth Circuit's decision is important because it raises fundamental questions as to the proper construction, interpretation, and application of ERISA plan terms. The decision also affects the continued viability of ERISA plans generally. Accordingly, this Court should grant the Petition for a Writ of Certiorari and accept this case for review.

I. THE DECISION BELOW CONTRAVENES THE POLICY OF ERISA BY FAILING TO APPLY UNAMBIGUOUS PLAN TERMS IN THEIR ORDINARY AND POPULAR SENSE

The interpretation and construction of the terms and provisions of ERISA-regulated insurance contracts must be governed by a uniform body of federal substantive law. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989). This body of federal law is drawn from the language of the statute itself and, where ERISA is silent, from the federal common law of ERISA as developed by the federal courts. *Fox Valley & Vic. Constr. Workers Pension Fund v. Brown*, 897 F.2d 275, 281 (7th Cir. 1990), *cert. denied*, 498 U.S. 820 (1990). It is by now well-settled that the federal common law of ERISA embodies the principle that plan terms must be given their plain, natural meanings and must be interpreted in an ordinary and popular sense as would a person of average intelligence and experience. *E.g., Brewer v. Protexall, Inc.*, 50 F.3d 453, 457 (7th Cir. 1995); *Evans v. Safeco Life Ins. Co.*, 916 F.2d 1437, 1441 (9th Cir. 1990). This established principle of ERISA plan interpretation is derived, in part, from the ERISA statute itself, which requires plan administrators to furnish plan descriptions "written in a manner calculated to be understood by the average plan participant." 29 U.S.C. § 1022(a)(1); *see Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991).

The decision below pays lip service to these general principles, acknowledging that the court was bound to "enforce the policy's plain language in its ordinary sense." Pet. App. 23a. Nevertheless, the court's holding does violence

to that principle by failing to apply plain, unambiguous terms as written to the facts before it. Any reasonable reading of the plan terms at issue in this case can only lead to the conclusion that no coverage was available under the Lincoln National contract. The plan's definition of the terms "preexisting condition" and "sickness" is written in a manner easily understandable by an average plan participant and clearly indicates that no benefits are available for medical services relating to a "sickness" (defined as a disturbance in the body's function or structure that causes physical signs and/or symptoms and which, if left untreated, would result in a deterioration of the health state of the body's structure or system) if, prior to the participant's effective date of coverage, he or she receives medical attention (defined as "care, treatment, services, medication, diagnosis or consultation") for that sickness. Pet. App. 23a. The facts of this case confirm that, at the very least, Respondent Barbara Hardester received care or treatment for a disturbance in her left breast prior to the effective date of her coverage. Pet. App. 14a-17a. Accordingly, under the plain terms of the foregoing provisions, the medical treatment directed to the problems with her left breast after the effective date of coverage fall within the preexisting condition exclusion. There simply is no justification for the court's additional requirement that the particular cause of the physical problem must be accurately diagnosed prior to the effective date of coverage for the preexisting condition exclusion to apply.

ERISA requires that plan descriptions be written in an understandable fashion so that all involved in the benefits process (insurers, employers, plan administrators, and plan participants and beneficiaries) will know precisely what benefits are provided under the subject plan. This worthwhile goal is defeated if courts refuse to apply express provisions in accordance with the common understanding of the language employed. In this respect, the First Circuit has made the following observation:

> Notwithstanding the ennobling purposes which prompted passage of ERISA, courts have no right to torture language in an attempt to force particular results or to convey delitescent nuances the contracting parties neither intended nor imagined. To the exact contrary, straightforward language in an ERISA-regulated insurance policy should be given its natural meaning.

Burnham v. Guardian Life Ins. Co. of America, 873 F.2d 486, 489 (1st Cir. 1989).

The preexisting condition exclusion at issue here is clear, unambiguous, and easily applied. The Fourth Circuit's failure to apply this provision in a straightforward manner may have benefitted Respondents, but at the expense of the certainty and uniformity mandated by ERISA. In light of the decision below, the various parties involved in the ERISA benefits arena — insurers providing health insurance contracts to ERISA plans, employers sponsoring and/or self-funding ERISA plans, ERISA plan administrators, and ERISA plan participants and beneficiaries — are left wondering how a given court will interpret express plan terms. This inevitably will lead to confusion as to precisely what benefits may be available under an ERISA plan. This Court should take this opportunity to confirm that federal courts called upon to interpret and construe terms in an ERISA-governed plan must do so in an ordinary and popular sense, to the end that all those with an interest in ERISA plan benefits will be able to gauge the actual benefits available to plan participants and beneficiaries.

II. THE DECISION BELOW WILL HARM THE INTERESTS OF ERISA PLAN PARTICIPANTS AND BENEFICIARIES BY INCREASING THE COST OF HEALTH CARE COVERAGE PROVIDED BY COMMERCIAL INSURERS

Insurance policies generally provide coverage only for losses sustained while the policies are in effect. Health

insurance contracts, like other forms of insurance, typically are designed to provide benefits only for medical conditions, sicknesses, or illnesses arising after the effective dates of coverage under the contracts. Accordingly, these contracts often contain express provisions precluding coverage for preexisting conditions. W. MEYER, LIFE & HEALTH INSURANCE LAW, § 17.1 at 548 (1972). The motivation behind these provisions is clear: health insurers seek to decrease the cost of their products by avoiding the "economic implications of insuring the health of persons already suffering from illnesses which would otherwise be covered under the insurer's policy." J. Williams, *Construction and Application of Provision in Health or Hospitalization Policy Excluding or Postponing Coverage of Illness for Which Medical Care or Treatment Was Received Within Stated Time Preceding or Following Issuance of Policy*, 95 ALR 3d 1290, 1292 (1979). The majority of health insurance policies issued in this country contain some form of preexisting condition provision excluding or limiting benefits for medical conditions predating the effective date of coverage. B. HARTNETT & I. LESNICK, THE LAW OF LIFE & HEALTH INSURANCE, § 6.07[3] at 6-119 (Matthew Bender 1995).[2]

The preexisting condition exclusion at issue in this case was designed to relieve Lincoln National from liability for medical expenses arising out of conditions for which the participant or beneficiary obtained treatment or consultation prior to his or her effective date of coverage. By negating the effect of such provisions, the Fourth Circuit's decision disrupts the risk and cost calculations underlying the issuance of the subject health insurance contract. The aggregate effect of this decision will cause substantial harm to those for whose benefit ERISA was designed. Faced with liabilities for preexisting conditions not contemplated at the

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[2] While most policies contain preexisting condition exclusions, in some cases they apply only to late enrollees. In addition, a majority of states has enacted laws prohibiting insurers from applying preexisting condition exclusions to certain employees who have maintained continuous health coverage.

time their contracts were issued, commercial insurers providing health care coverage to ERISA plans will be forced either to charge higher premiums for the same level of prior benefits, or to provide a decreased level of benefits for participants and beneficiaries. Employers offering such plans to their employees similarly will be forced to decide whether to require increased premium contributions from employees or to reduce available benefits. Invariably, the price of forcing commercial insurers to cover preexisting conditions will be paid by ERISA plan participants and beneficiaries. The stated goals of ERISA look unfavorably upon such a result.

III. THE DECISION BELOW CONTRAVENES THE NATIONAL INTEREST IN PROMOTING ERISA PLANS AND PROTECTING PLAN ASSETS FOR THE BENEFIT OF PARTICIPANTS AND BENEFICIARIES AS A WHOLE

A primary purpose of ERISA is to encourage private sector employers to establish and maintain employee benefit plans, and to secure the stability of these plans once established. *Holmes v. Pacific Mut. Life Ins. Co.*, 706 F. Supp. 733, 735 (C.D. Cal. 1989). ERISA, however, does not *require* employers to establish benefit plans; this decision is left entirely to the employer's discretion. *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1329 (3d Cir. 1991). Moreover, ERISA has no bearing on an employer's decision as to the type or amount of benefits included in a plan. *See, e.g., Moore v. Reynolds Metals Co. Retirement Program for Salaried Employees*, 740 F.2d 454, 456 (6th Cir. 1984), *cert. denied*, 469 U.S. 1109 (1985); *Coble v. Bonita House, Inc.*, 789 F. Supp. 320, 321 (N.D. Cal. 1992) ("ERISA does not mandate the provision of health insurance coverage by employers, any particular type of coverage that must be provided, or any changes in the scope of coverage").[3]

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[3] The flexibility afforded employers in deciding what benefits to offer under ERISA-regulated plans is particularly important in the context of medical coverage. For example, in denying a claim by retirees

An employer offering employee welfare benefits is free to establish the type and amount of medical benefits it will provide. Given the voluntary nature of ERISA plan sponsorship, the cost of providing such coverage clearly is relevant; indeed, in seeking to promote such plans through ERISA regulation, Congress recognized that it must take into account additional costs from the employer's standpoint. *See Hozier v. Midwest Fasteners, Inc.*, 908 F.2d 1155, 1160 (3d Cir. 1990); *Holmes*, 706 F. Supp. at 735.

This point is made abundantly clear in *Burnham v. Guardian Life Ins. Co. of America*, 873 F.2d 486 (1st Cir. 1989). In *Burnham*, the Court of Appeals for the First Circuit held that a group life insurer correctly denied life insurance benefits to the plaintiff because her decedent was not an eligible "full-time employee" under the terms of the plan. The court rejected the plaintiff's claim that a literal construction of the plan contravened ERISA's policy to promote the interests of beneficiaries, stating as follows:

> Safeguarding the interests of employees as a whole is a multifaceted endeavor. Any time coverage is less than universal, line-drawing becomes a necessary evil. . . . [T]he contracting parties (employer and insurer) had the right to plot the line as they saw fit, so long as the coordinates were rationally related to meet a lawful objective of the plan.

Id. at 490. The court further disposed of the plaintiff's argument that application of the policy language was improperly applied to her:

> It cannot validly be argued that all ERISA plans must pass an "as applied" test. *Almost by definition, group plans require generalization. They focus*

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that their employer could not change their medical benefits, the Second Circuit noted that limiting an employer's right to change medical plans risked decreasing protection for future employees and retirees due to the realities of inflation and changes in medical practices and treatments. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988).

> *on verifiable benchmarks, sparing the need for in-depth investigation of the circumstances of each and every claim.* That a seeming inequity may result on occasion is not fatal to the plan's legitimacy: after all, as we said in an earlier ERISA case, "*the necessity to draw hard boundary lines, inevitably adversely affects some individuals who find themselves on the wrong side of a line.*"

Id. (emphasis added) (quoting *Rueda v. Seafarers Int'l Union of North America*, 576 F.2d 939, 942 (1st Cir. 1978)).

The same reasoning holds true in this case. In providing health care coverage for the plan in which Respondents participated, Lincoln National drew a line with respect to available benefits for treatment of preexisting conditions. This case arose simply because, unfortunately, Respondents found themselves on the wrong side of the line. It is clear, however, that this line (and indeed every other limitation of the Plan that made coverage anything less than universal) reduced the costs of the insurance to Respondents' employer and, therefore, promoted the maintenance of the plan for all employees. If no such limitation were present, obviously the cost of providing the insurance would have increased.

Furthermore, in applying the preexisting condition exclusion, Lincoln National simply upheld a line drawn for the purpose of reducing the risk and cost associated with conditions predating coverage. The continued availability of benefits for all participants in the plan is affected by payment of claims beyond those contemplated in the insurance policy. The reason is simple: premiums charged for insurance naturally will rise in proportion to the amounts paid for claims. In other words, excessive claims experience ultimately results in a decrease or elimination of Plan benefits (or a corresponding increase in employer/employee premium contributions) as these costs are passed through.

The Fourth Circuit's decision in this case at first glance

may appear to comport with ERISA's stated objective "to protect the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); *see* 29 U.S.C. § 1001(b). This Court, however, has noted the need to balance the "tension between the primary [ERISA] goal of benefitting employees and the subsidiary goal of containing pension costs." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 515 (1981); *see Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2072 (1993) (noting concern over indirectly exposing ERISA plans to liabilities that would increase plan costs).

A number of Circuit Courts of Appeals, including the court below, similarly have recognized that protecting the financial integrity of employer-provided welfare plans is a primary goal of ERISA. *See Auto Owners Ins. Co. v. Thorn Apple Valley, Inc.*, 31 F.3d 371, 375 (6th Cir. 1994), *cert. denied*, 115 S. Ct. 1177 (1995); *Coleman v. Nationwide Ins. Co.*, 969 F.2d 54, 60 (4th Cir. 1992), *cert. denied*, 113 S. Ct. 1051 (1993); *Peckham v. Gem State Mut. of Utah*, 964 F.2d 1043, 1050 n.12 (10th Cir. 1992); *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992). The financial integrity of ERISA-governed employee welfare benefit plans clearly is at stake as a result of the ruling below. This decision will expose commercial health insurers to liability for preexisting conditions and thereby force them to assume risks not anticipated at the time their products were offered for sale and for which no premium was received. Because this broad level of increased cost naturally will filter down to — and be absorbed by — employers, participants, and beneficiaries, the Fourth Circuit's decision contravenes fundamental ERISA policy. *See, e.g., Auto Owners*, 31 F.3d at 375 (construing ERISA plan's coordination of benefits provision "to comply with a primary goal of ERISA, which is to safeguard the financial integrity of qualified plans by shielding them from unanticipated claims"); *Coleman*, 969 F.2d at 60 (refusing recovery of health insurance benefits by plan beneficiary following employer's failure to pay required premium and noting that

"[t]he financial integrity of a group health insurer could be quickly compromised if courts compelled the insurer to assume risks for which no premium was ever paid"). Indeed, as the Third Circuit has observed, failure to apply plan terms and limitations as written prejudices the plan as a whole and deprives employers and participants "of an important weapon in their joint battle against rising healthcare costs." *Nazay v. Miller*, 949 F.2d 1323, 1338 (3d Cir. 1991).

The tension between assuring receipt of benefits by ERISA plan participants and beneficiaries and protecting plan assets from undue financial burden also is informed by the statutory duties of an ERISA plan administrator. ERISA requires an individual acting in this capacity to discharge his or her duties with due regard for *both* the interest in providing benefits to participants *and* the interest in defraying reasonable expenses of plan administration. 29 U.S.C. § 1104(a)(1)(A). In addition, the administrator must discharge his or her duties with the care, skill, prudence and diligence that a prudent person would use under the circumstances. *Id.*, § 1104(a)(1)(B). Consequently, in making benefit determinations, the administrator of an ERISA plan must strike a balance between the interests of a claimant beneficiary and the plan itself. *See, e.g., LeFebre v. Westinghouse Elec. Corp.*, 747 F.2d 197, 207 (4th Cir. 1984) ("A trustee has the obligation to guard the assets of the trust from improper claims, as well as the obligation to pay legitimate claims"); *Morse v. Stanley*, 732 F.2d 1139, 1145 (2d Cir. 1984) ("The trustee must deal even-handedly among [the beneficiaries], doing his best for the entire trust looked at as a whole"); *see also Curtis v. Noel*, 877 F.2d 159, 162 (1st Cir. 1989).

Health insurance contemplates an allocation of risk and cost based on historical patterns of claim liability. It also implicates a fundamental trade-off between product affordability and universal access to health care. As with any product, the cost of health insurance must rise if additional benefits are guaranteed. By forcing health insurers

to provide coverage for preexisting conditions clearly excluded by the terms of their plans, the decision below will alter the benefits available to a vast number of ERISA plan participants and beneficiaries. The fallout from this decision will extend to employer decision-making in terms of the establishment and maintenance of employee welfare benefit plans, and will affect the financial viability of existing plans. Given the competing interests represented in ERISA, this Court should recognize the dangers inherent in the decision below and accept this case for review.

CONCLUSION

For the reasons set forth above, the Health Insurance Association of America supports the Petition for a Writ of Certiorari in this case.

Respectfully submitted,

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No. 95-66

IN THE SUPREME COURT OF THE UNITED STATES

October Term 1995

LINCOLN NATIONAL LIFE INSURANCE COMPANY AND EMPLOYERS HEALTH INSURANCE COMPANY,
Petitioners,

V.

ALLEN L. HARDESTER, JR. AND BARBARA HARDESTER,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Should this Court should grant *certiorari* to review the determination that the plain language of a "pre-existing condition exclusion" in plaintiff's health insurance contract did not allow defendants to avoid coverage for the treatment and care of a malignant cancer?

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NO. 95-66

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1995

Lincoln National Life Insurance Company and Employers Health Insurance Company,

Petitioners,

v.

Allen L. Hardester, Jr. and Barbara Hardester,

Respondents.

BRIEF IN OPPOSITION

Respondents, Allen L. Hardester, Jr. and Barbara Hardester, respectfully request that this Court deny the petition for writ of certiorari which seeks review of the Fourth circuit's opinion below.

STATEMENT OF THE CASE

Stripped to its essence, this case involves only a matter of contract interpretation. Because the recitation of facts is crucial to understand the Fourth Circuit's reasoning and the limited nature of its holding, Respondents wish to briefly review the facts of the case and correct some discrepancies between the undisputed record, to which both the various opinions refer, and Petitioners' "Statement of Facts."

In August of 1981, Barbara Hardester was diagnosed with fibrocystic disease. Fibrocystic disease is a "benign condition of the breast marked by fibrous tissue and cyst formation," which may, in some cases, "result in the formation of a firm area in the breast called a mass." Pet. App. at 8a n.1. However, as both the District Court and the panel dissent expressly pointed out, fibrocystic disease "*is not* cancer, and *does not develop* into cancer; indeed, it does no

harm to a woman's physical health at all." Pet. App. at 21a (Hall, J. dissenting) (emphasis in original). *See also* Pet. App. at 29a ("Despite its characterization as a 'disease,' the [fibrocystic] condition is not one which in and of itself causes any deterioration in health. Fibrocystic breast disease does not cause cancer.").

The fibrocystic disease did not manifestly result in any symptoms to Mrs. Hardester until April 17, 1991, when, during Mrs. Hardester's annual gynecological checkup, Dr. Barbara Phillips-Seitz ("Phillips-Seitz") found small masses on both breasts. Petition at 3. However, Petitioners omit from their recitation an important sequence of events following this discovery. Because Dr. Phillips-Seitz' normal practice was to "refer[] 'anybody with a fibrocystic condition' to a surgeon," Pet. App. at 21a n.1 (Hall, J. dissenting), Dr. Phillips-Seitz referred Mrs. Hardester to Dr. Mary Boyle, a surgeon, for further examination. Pet. App. at 9a. After

examining Mrs. Hardester in May 1991, Dr. Boyle concluded that the masses were nothing more than manifestations of the fibrocystic disease. Pet. App. at 9a.

Mrs. Hardester's next annual gynecological checkup occurred on April 6, 1992. During this visit, Dr. Phillips-Seitz found an "clongated ropey mass" on Mrs. Hardester's left breast ("1992 mass"). Again, Dr. Phillips-Seitz referred Mrs. Hardester to Dr. Boyle. Petitioners imply that this referral indicates that Dr. Phillips-Seitz "was more concerned about the possibility of breast cancer that she had been the previous year." Petition at 3. The record indicates, however, that Dr. Phillips-Seitz was simply following her regular procedure and did not suspect the 1992 mass to be cancerous. *See, e.g.,* Petition at 21a n.1 & 29a. In fact, both the District Court and Judge Hall pointed out that had Dr. Phillips-Seitz been concerned about cancer, she would have referred Mrs. Hardester to Dr. Boyle within a day rather than the several

weeks that it actually took. Pet. App. at 21a n.1 and 32a n.3 (if there is "any substantial likelihood" that her patient has cancer, Dr. Phillips-Seitz refers the patient to "a surgeon on that day or the next day.").

On May 1, 1992, at 12:01 a.m., Mrs. Hardester became eligible for benefits under a group health insurance plan issued by the defendants to the employer of her husband. Later that day, Dr. Boyle examined Mrs. Hardester and concluded the 1992 mass was due to the fibrocystic disease. Dr. Boyle then recommended that Mrs. Hardester receive a mammogram because it had been "more than a year" since Mrs. Hardester last had one. Petition at 29a n.1. Mrs. Hardester's mammogram, performed May 7, 1992, turned out negative.

On May 15, 1992, Dr. Boyle removed a mole from Mrs. Hardester's breast. Following that procedure, Dr. Boyle recommended a biopsy of the 1992 mass. After the 1992

mass was removed, doctors found that most of the 1992 mass consisted of fibrocystic disease. However, the fibrocystic mass completely encased a malignant carcinoma that was so small (9 mm across) that it would have avoided detection had it not happened to be encased within the fibrocystic mass. Even though the carcinoma was removed, Mrs. Hardester still had to undergo chemotherapy to prevent recurrence of breast cancer.

Mrs. Hardester then filed a claim for benefits for the surgery and chemotherapy. Petitioners refused to pay on the basis of the policy's pre-existing condition exclusion in the Plan. Under the Plan, a pre-existing condition is any "Sickness or Bodily Injury for which You have received medical attention, (care, treatment, services, medication, diagnosis or consultation)" prior to the effective date of the policy. "Sickness" is defined in three parts: (1) a "disturbance in function or structure of [the] body"; (2)

"which causes physical signs and/or symptoms"; and (3) "which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of [the] body." Pet. App. at 9a. After exhausting Petitioners' internal remedies, Mrs. Hardester, along with her husband, filed suit.

The District Court granted summary judgment to the Hardesters. Holding that the case "can be decided on its own narrow facts," the court ruled that Mrs. Hardester had not received any "medical attention" within the meaning of the policy's language for the breast cancer, and that the fibrocystic disease was not a "sickness" within the meaning of the policy because it did not cause any "deterioration of plaintiff's health." Pet. App. at 31a – 32a.

Reviewing *de novo*, a divided Fourth Circuit panel reversed and remanded with instructions to grant summary judgment to Petitioners. However, in a *per curiam* opinion, the *en banc* Fourth Circuit, by a vote of 7–6, adopted the

reasoning of the panel dissent and ruled that, according to the unique facts of this case, "Mrs. Hardester's breast cancer was not a 'preexisting condition'" under the plain language of the insurance policy. Pet. App. at 23a (Hall, J., dissenting). It is the application of these facts to the insurance contract that Petitioners ask this Court to review.

REASONS FOR DENYING THE WRIT

This case does not warrant review by this Court for two reasons. First, as Petitioners have conceded in a different context, this dispute is primarily one of fact, and there is no significant legal issue, let alone an important issue of federal law, that would justify the expenditure of this Court's limited time and resources. In addition, any rule of law which this Court might issue would be limited not only to the unique facts of this case, but also to the pertinent language of the insurance contract, which can be changed at any time by Petitioner or any other insurance company.

Second, no inter-Circuit conflict exists. The Courts of Appeals have taken essentially a unified approach when applying pre-existing condition exclusions to undiagnosed illnesses, and the outcomes differ only because each case is applying unique facts to particular policy language.

A) The Petitioner Presents No Significant Issue Of Federal Law That Would Be Worthy Of The Expenditure Of This Court's Limited Time And Resources.

Petitioners themselves have recognized that the fact-specific nature of cases such as these means that there is no "significant legal question" to be resolved by any court. In their January 31, 1994 opposition to a motion for attorney fees, Petitioner Lincoln National Ins. Co. wrote:

> [P]laintiff's lawsuit did not raise a "significant" legal question regarding ERISA itself. The dispositive issue in this case was one of fact, not of law. . . . No substantive legal issue under ERISA were {*sic*} raised by either of the parties and none was decided by the Court.

Following the *en banc* ruling, Lincoln National Ins.

Co. again forcefully argued against an award of attorney fees because of the fact-specific basis for the decision. In Lincoln National Ins. Co.'s June 1, 1995 opposition to Hardester's supplemental motion for attorney fees they state:

> [P]laintiffs' complaint did not raise or resolve any significant legal questions regarding ERISA itself. Indeed, the dispositive issue in this case was one of fact, not law. This Court acknowledged that it decided the case "on its own narrow facts." Hardester I, 841 F. Supp. at 716. The dissent in Hardester II (which ultimately was adopted as the opinion of the en banc Court in Hardester III), agreed that "just as (the District Court) resolved the case in Mrs. Hardester's favor on the terms of the clause, so also would I." Hardester II, 33 F.3d at 340.

Thus, this case does not present an "important federal question" as required by Supreme Court Rule 10.

In addition, all three Circuits which have addressed similar circumstances have recognized its duty is to "view the language of the insurance policy to determine where the parties' minds met." *See Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429, 432 (7th Cir. 1994). Accord Pet.

App. at 14a. Because the question faced by the courts on this issue is simply a matter of contract interpretation, and because the language of the contracts can be prospectively changed as a result of either bargaining between the two parties or, more realistically, unilateral action by the company, any decision that this Court might render would have little precedential or practical value.

B) The Decision Below Does Not Conflict With Any Decision Of A Federal Court Of Appeals.

Contrary to Petitioners' argument, this case does not conflict with *Bullwinkel v. New England Mut. Life Ins. Co.*, 18 F.3d 429, 432 (7th Cir. 1994) (pre-existing condition exclusion covered treatment for a lump/cyst which doctors suspected but could not definitely conclude to be cancerous) and *Kirk v. Provident Life & Acc. Ins. Co.*, 942 F.2d 504, 506 (8th Cir. 1991) (divided panel ruled that pre-existing condition exclusion applied to an aortic valve surgical

replacement that resulted from bacterial endocarditis because insured had manifested symptoms four months prior to surgery which "were consistent with a diagnosis of endocarditis").

All three Circuits understand, first and foremost, that this type of case is simply one of contract interpretation, and that the resolution of the cases hinge on the interpretation of the contract as applied to the specific facts found by the fact-finder. See Pet. App. at 13a ("This case . . . requires us to apply federal common law rules of contract interpretation when interpreting the terms of an employee health insurance policy"); Pet. App. at 32a-33a ("Since the case can be decided on its own narrow facts, I need not decide the broader question it presents"); *Bullwinkel*, 18 F.3d at 430 ("Generally, this case concerns an insurance policy, which is a contract . . . .[The Bullwinkels] and the insurance company disagree on its meaning"); and *Kirk*, 942 F.2d at 505

(interpreting terms of policy). See also *Pitcher v. Principal Mut. Life Ins. Co.*, 870 F.Supp 903, 908 (SD Ind. 1994) ("Because each case is governed by a specific contractual provision, of course, the precedents are of limited value. This case must be decided by applying the specific language of this pre-existing condition clause to this specific factual situation.").

The pre-existing condition clause in *Bullwinkel*, 18 F.3d at 430, defines "sickness" as a "bodily disorder, disease, or mental infirmity or complication of pregnancy". Hardester's policy contains the following underlined qualifier:

> A disturbance in the function or structure of Your body, which causes physical signs and/or symptoms and which, if left untreated, will result in a deterioration of the health state of the structure or system(s) of Your body. Pet. App. at 31a.

Such differences of contract language partially explains the disparate result reached by the circuit court in *Bullwinkel* and *Hardester*. To illustrate, the fibrocystic

condition suffered by Hardester was not a "sickness" under her policy but would have been considered a "sickness" under the Bullwinkel policy. ***Bullwinkel***, 18 F.3d at 431.

The reasoning used by the Fourth Circuit is essentially identical to that used by the Eighth Circuit in ***Kirk*** and the Seventh Circuit in ***Bullwinkel***. In ***Kirk***, the Eighth Circuit upheld the right to coverage exists only when the insured has "some supposedly trivial infirmity or abnormality when the policy took effect," but whose condition later on "changed for the worse and for the first time either actually became, or became diagnosable as, a sickness or disease falling within the coverage of the policy." ***Kirk***, 942 F.2d at 506 (citing ***State Nat'l Life Ins. Co. v. Stamper***, 312 S.W.2d 441, 442 (Ark. 1958)). Similarly in ***Bullwinkel***, the Seventh Circuit, analogizing ***Kirk***, ruled that "even though [the insured] did not know the lump was cancerous in July, her visit with the doctor in that month concerning the lump actually concerned

cancer," and the symptoms which the insured exhibited in July were not "trivial or inconclusive--like a cough or a rash which might imply any of a variety of maladies, or none at all." *Bullwinkel*, 18 F.3d at 432.

Accordingly, the pre-existing condition exclusion applied in *Bullwinkel* and *Kirk* because symptoms, relating to the disease in question, manifested themselves prior to the effective date of the policy. *Kirk*, 942 F.2d at 506. *See also Bullwinkel*, 18 F.3d at 433 (if Bullwinkel's attorney had argued that a lump found to be cancerous in September "could have been caused by any number of maladies other than cancer," the case would have gone to fact-finder). Conversely, since Mrs. Hardester had no underlying symptoms related to cancer and since her cancer was unpalpable and was only discovered when a biopsy found it was coincidentally encased within the fibrocystic mass, under the reasoning of the Seventh and Eighth Circuits, the pre-

existing condition exclusion would not have applied.

In fact, Mrs. Hardester's illness more closely resembles the fact pattern in *Stamper* than in *Kirk*. In *Stamper*, the insured had a small bony growth on the back of her head for most of her life. After her insurance policy became effective, the bony growth began to increase in size and caused her some pain. Because the growth "did not manifest itself as a problem until after the coverage began," the Arkansas Supreme Court ruled that the pre-existing condition exclusion did not apply. *Kirk*, 942 F.2d at 507 (citing *Stamper*, 312 S.W.2d at 442).

Finally, there is no conflict among the three cases because *Bullwinkel* and *Kirk* involve a very different factual pattern. Both *Kirk* and *Bullwinkel* addressed situations where the actual disease, while undiagnosed, caused obvious symptoms that could later be directly attributed to the disease. *See Kirk*, 942 F.2d at 506 ("while there was no objective data

to confirm a diagnosis of endocarditis . . . [the] symptoms were indications that the infection was present") and *Bullwinkel*, 18 F.3d at 432 ("even though Madelaine did not know the lump was cancerous in July, her visit with the doctor in the month actually concerned cancer"). In Mrs. Hardester's case, because "*the undisputed medical record* [indicates that] *there was no causal or associative relationship between the fibrocystic tissue and the carcinoma*," Pet. App. at 25a (Hall, J. dissenting) (emphasis in original), Mrs. Hardester neither knew nor had any reason to know of the existence of cancer." Pet. App. at 33a. Moreover, as the Seventh Circuit explicitly noted in *Bullwinkel*, its discussion is not supposed to be an "authorization for summary judgment in all future cases dealing with pre-existing condition limitations" because of the factual uniqueness of the case. *Bullwinkel*, 18 F.3d at 433. Because all of the Courts that have examined pre-

existing condition clauses recognize the fact-based and contract-dependent nature of the inquiry, there is no conflict for this Court to resolve.

CONCLUSION

The writ of *certiorari* should be denied.

Respectfully submitted,

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August 28, 1995

Supreme Court, U.S.
FILED
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CLERK

No. 95-66

In the Supreme Court of the United States

OCTOBER TERM, 1995

LINCOLN NATIONAL LIFE INSURANCE COMPANY and
EMPLOYERS HEALTH INSURANCE COMPANY,

PETITIONERS,

v.

ALLEN L. HARDESTER, JR. and BARBARA HARDESTER,

RESPONDENTS.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITIONERS' REPLY BRIEF

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**Counsel of Record*

In the Supreme Court of the United States

OCTOBER TERM, 1995

No. 95-66

Lincoln National Life Insurance Company
and Employers Health Insurance Company, Petitioners,

v.

Allen L. Hardester, Jr. and Barbara Hardester, Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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PETITIONERS' REPLY BRIEF

Respondents argue that, because this action is "fact-specific," the petition for a writ of certiorari should be denied. (Brief in Opp., p. 9). In support of this argument, respondents cite to arguments made by petitioners in opposition to respondents' motion in the district court for attorney's fees. (*Id.*) Respondents fail to disclose, however, that the district court expressly rejected the argument now advanced by respondents. The district court, awarding respondents' attorney's fees, found this "argument to be unpersuasive." Indeed, the district court stated that

> Lincoln National chose to interpret its policy language and the facts in the medical record against Mrs. Hardester in an unduly narrow manner. Other

> insurers should be encouraged to act with greater breadth of vision.

(App., *infra*, 2a).

Respondents further argue that the instant petition should be denied because petitioners argued in opposition to respondents' motion for attorney's fees that the case did not "raise or resolve any significant legal questions regarding ERISA." (Brief in Opp., p. 10). Once again, respondents fail to disclose that the district court rejected this argument, holding that this case "had substantial precedential value."[1] (App., *infra*, 3a). The district court opined that this action had precedential value because it "involved the interpretation of standard policy language." (*Id.*)

The reasons advanced by respondents as grounds for this Court to deny review already have been rejected by the district court. Respondents cannot benefit from the explicit findings of the district court for purposes of their claim for attorney's fees, and then reject those same findings for purposes of opposing the petition.

The petition filed in this action involves the interpretation of standard plan language that covers thousands of individuals nationwide. (Petition, pp. 7-8; Brief of the Health Insurance Assn. of Am. as Amicus Curiae, p. 2). Respondents admit as much when they assert that this matter involved "contract interpretation." (Brief in Opp., p. 12). The "contract" to which respondents refer is part of an ERISA plan in force in numerous jurisdictions. Resolution of the question presented has significance to all of the persons covered by this plan, as

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[1] Respondents likewise represented to the district court that this case "represents very significant case law." (Plaintiffs' supplemental motion for attorney's fees, pp. 2-3).

well as all other plan participants covered by substantially similar plan provisions. The petition for a writ of certiorari should be granted.

Respectfully submitted,

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September 8, 1995

UNPUBLISHED

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

ALLEN L. HARDESTER, JR., et al.	*	
	*	
v.	*	Civil No. JFM-93-1685
	*	
LINCOLN NATIONAL LIFE INSURANCE COMPANY, et al.	*	

*****

MEMORANDUM

Plaintiffs, having ultimately prevailed in this case after the Fourth Circuit, sitting *en banc*, affirmed the judgment that I entered in favor of plaintiffs, have now filed a motion seeking the award of attorneys' fees in the amount of $59,758.72 and court costs in the amount of $646.00. Defendants have not challenged the reasonableness of the amount of fees and costs requested but contend that fees and costs should not be awarded at all.

The Fourth Circuit has outlined five factors that are to be considered in determining whether attorneys' fees should be awarded in an ERISA case:

(1) degree of opposing parties' culpability or bad faith;

(2) ability of opposing parties to satisfy an award of attorneys' fees;

(3) whether an award of attorneys' fees against the opposing parties would deter other persons acting under similar circumstances;

(4) whether the parties requesting attorneys' fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA itself; and

(5) the relative merits of the parties' positions.

Reinking v. Philadelphia American Life Ins. Co., 910 F.2d, 1210, 1217-18 (4th Cir. 1990); *Quesinberry v. Life Ins. Co. of North America*, 987 F.2d 1017, 1029 (4th Cir. 1993).

In exercising my discretion as to whether to award fees here, my evaluation of the five factors is as follows:

1. Bad Faith - In light of the fact that six judges of the Fourth Circuit agreed with defendants' position, I do not find that defendants acted in bad faith.

2. Ability to Pay - Defendants do not deny that they have the ability to pay plaintiffs' fees and costs.

3. Deterrence - Defendants argue that awarding fees against them would not help deter other insurers acting under similar circumstances because this case turned on its own particular facts. I find that argument to be unpersuasive. Almost every decision as to whether to pay benefits turns upon the claimant's particular medical history and condition. Here, Lincoln National choose [sic] to interpret its policy language and the facts in the medical record against Mrs. Hardester in an unduly narrow manner. Other insurers should be encouraged to act with a greater breadth of vision. By the same token, the failure to award fees would have deleterious effects. Undoubtedly, if fees were not awarded, in future cases insurers and their counsel would attempt to prevent claims from being filed, or at least to settle them at a very low value, by advising plaintiffs and their counsel that even if the plaintiffs were to prevail, their victory would be pyrrhic in

light of the amount of attorneys' fees they would have to incur in order to obtain it.

4. Precedential Value - Although this case (like almost all cases) did turn on its own facts, it had substantial precedential value. It involved the interpretation of the standard policy language. Further, it involved at its foundation the fairness of construing ambiguous language concerning pre-existing conditions to prohibit a claim by a beneficiary who had no knowledge of that pre-existing condition. In the future, at least in the Fourth Circuit, if insurers intend to deny benefits to a person who has no knowledge when she obtains coverage that she suffers from a condition that will require treatment after the coverage becomes effective, they will have to say so clearly and expressly.

5. Relative Merits - Although the defendants' argument was persuasive to some of the Fourth Circuit, ultimately the plaintiffs were found to be correct.

Having found that four of the five factors weigh in favor of plaintiffs, I will grant them attorneys' fees and costs in the amount requested, which I have considered and find reasonable.

A separate order effecting the ruling made in this memorandum is being entered herewith.

Date: June 12, 1995

J. Frederick Motz
United States District Court